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ORIGINAL ARTICLES.

FOREIGN-BODIES IN THE EAR: A WARNING.

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A patient, his relatives or friends, may often declare sincerely, under a positive conviction of its truth, that there is a foreign-body in the ear, and may importune—Nay! even demand its immediate dislodgement by interference at the hands of the medical practitioner. This is one of those crises where the physician must not lose his self-command; must be deliberate; must stand firmly on the rock of our calling, "*Be sure you're right; then go ahead!*"

Except when there is adequate reason for presuming that there is a live insect, or a corrosive chemical, within the ear, producing intolerable pain—where avoidable delay would be unnecessarily cruel, since an immediate instillation of or gentle syringing with warm water may give instantly temporary relief, with the least possibility of an injury to uninvolved parts,—with that exception: No matter how positive a patient, his relatives or friends, may be, that there is a foreign-body in his ear, never attempt the removal of such until you have first provided yourself with satisfactory illumination of the canal, examined the ear thoroughly by ocular in-

spection, and convinced yourself of the presence of a foreign-body.

To apply this rule invariably, with but the single exception above noted, is to protect the best interests of your patient and yourself; to disregard it, is to court disaster, as experience demonstrates not infrequently.

"How *not* to do it," and its consequences, are well illustrated by the following, from the writer's aural records:

Suspected Bug in the Ear; Drumhead Injured by Mal-treatment.—This gentleman (404102) on experiencing some unusual fluttering sensation in his right ear, thought that a bug had flown into it, and forthwith "poked at it with a pin," hoping to dislodge the suspected intruder. Failing in this, he sought the assistance of his office-boy, who also, employing similar measures, failed. Immediately thereafter, our patient consulted a reputable physician, who "worked at it in vain for an hour; poked it, and syringed it repeatedly," until discouraged; and "put no cotton into the ear after syringing."

The "movement of the bug" (?) persisting, and the ear having begun to ache, the patient was referred to the writer for further advice and assistance.

The above is substantially the statement made by the patient at our consultation, the following morning.

On careful examination at that time,

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the parts were found (Fig. 1) congested; particularly so, the manubrial plexus of blood-vessels. There was an abrasion of the postero-superior canal-wall, near the drum-head. A spot, resembling a traumatic perforation of the drum-head, just healing, was found just behind and on a level with the middle of the handle of the malleus. Whether this was really a perforation, or merely an abrasion of the drum-head, might readily have been determined; but would have necessitated, therefor, a displacement of the parts. And, inasmuch, as these seemed already disposed as favorably as possible for repair with least resultant deformity, it was deemed inadvisable to disturb them merely for the purpose of determining that question.

There was *no foreign-body* in the auditory canal!

Except for a gentle application of *Succus calendulae* to the wounds, the ear was not disturbed; and complete recovery ensued within a few days.



FIG. 1.

Suspected Pebble in the Ear; Drum-head and Canal-wall Injured by Maltreatment.—The mother of this three-year-old boy (104 275) took him to a physician, stating that he had "got a pebble into his right ear;" that his sister, five-and-one-half-years-old, had "put the pebble into his right ear at least they said she had;" that on examining the ear herself, and seeing what she believed to be the pebble, she had "tried" in vain "to get it out with a hairpin," until warned to desist by the child's complaints of "its hurting him." The pebble, she said, was by that time beyond sight. The little fellow experienced no special discomfort until his visit to the physician, who, presuming upon the mother's statement (substantially repeated above) and without making ocular inspection, attempted to dislodge the pebble by probing or raking the depth of the

auditory canal with a steel-scoop or ear-spoon. He failed; but persisted in the attempt until impelled to desist by the screams and struggles of the child.

On the following morning this procedure was repeated, but more vigorously, by this physician; an efficient corps of "assistants" being employed to "hold" the little victim. Notwithstanding, the foreign body was not dislodged; but a "scraping sound" and a profuse hemorrhage rewarded the efforts at extraction.

The patient was taken by his mother, late on the same day, to another physician, who finding the ear badly injured, the condition of the parts unfamiliar, and the patient unmanageable, referred the case to the writer.

The terror of the child at our first consultation was pitiable, and was not surprising when the mother had stated, besides the above, that "she knew there was a pebble in his ear, for she had heard the instrument of the [first] doctor scrape against it while poking his ear." The sero-sanguinolent discharge from the meatus, of course aroused the writer's suspicion that the "scraping sound" had probably been that produced by the rasping of instruments upon forcibly-denuded bone,—doubtless upon the osseous auditory canal.

Informing the mother that if a foreign-body were present within the ear, and if the patient should, under my treatment, remain so restless and unmanageable, removal would have to be attempted under general anæsthesia; the writer advised a policy of gentle conciliation and mild treatment for a little. At the consultation, therefore, although the ear was discharging sero-sanguinolent fluid, nothing further was attempted than to gain the good-will and confidence of the little patient. This attempt was so far successful that at the next visit, upon the following morning, he allowed a gentle aural insufflation of powdered Boracic acid, and the placing of a wad of absorbent cotton in the concha of the injured ear. At the next, an afternoon visit, he allowed the introduction of a speculum, and a partial removal of the discharge with the cotton dossil. Thus, gradually, his confidence was gained, and at a thorough examination which he submitted to, a little later, it was discovered that the soft parts of the postero-superior canal-wall near the drum-head, together with the neighboring por-

tion of the membrana flaccida and vibrating drum-head, had been torn away from their bony attachment, and were flapping loosely in the discharges that filled the lumen of the auditory canal. The postero-superior osseous canal-wall was found partially denuded; and it was doubtless here that the impact of instruments had made the "scraping-sound." *No foreign-body* was found within the ear. After dressing the parts for a day or two with powdered Boracic acid until this last fact was demonstrated to his satisfaction, the writer explained the aural condition to the mother, informing her that he could find no foreign-body within the ear, and expressed the opinion that it was probable that she had been mistaken as to there having been one there. Her spirited denunciation of his ignorance and clumsiness in failing to discover the condition of which she had become so firmly convinced, and her rash threat of "getting some one to get the pebble out!" elicited from him a serious warning to the effect that "if she had been as positive and as importunate with the other Doctors as she had been with him, they were the more excusable for having done what he confidently could and would positively refuse to do;" and that "if she should obstinately persist in having the little boy's ear scraped for the removal of a foreign-body—which was not there—the suffering, and the deafness, and perhaps

even the death of her child would be upon her own head, and due solely to her own obstinate and unreasonable prejudice respecting this matter of fact of which she had conclusively proven herself—as she naturally should be—incompetent to judge."

She did not return until weeks afterward, when she informed the writer that she had discontinued medical treatment with her preceding visit to him; that, "except for his otorrhea, the boy had suffered no further discomfort from the presence of the pebble within the ear, which had not yet been removed," (?) but that "maybe the writer was mistaken about it, for she felt confident that it was still there." (?) Whereupon, with a few remarks as to the prognosis in tympanic abscess, the foregoing warning was repeated—and the case drifted into more obsequious, doubtless more skillful hands!

Instructive cases these! whose lesson, from a practical standpoint, is obviously that implied in the proverbial: "How to cook a hare. First—*Catch your hare!*" liberally translated for our purpose: To remove a foreign-body from the ear. First—*The foreign-body actually within the ear.* To sum up: As with every other abnormal or morbid condition, whatsoever and wheresoever, so with foreign-bodies in the ear: Diagnosis, first; TREATMENT, LAST!

THE ANTISEPTIC DRESSING OF THE UMBILICAL STUMP.

HIRAM CORSON, M. D., PLYMOUTH MEETING, PA.

In the editorial pages of the *Journal of the American Medical Association* (April, page 634) reference is made to an earnest plea, made by Dr. Joseph Allen (*American Journal of Obstetrics*) for more care of the cord in new-born children, and the article commended. And what does Dr. Allen recommend?

"The cord is ligated temporarily or clamped till after the nurse has washed the child. The accoucheur, having previously washed his hands and the child's abdomen and cord in an antiseptic solution, releases the ligature, strips the cord, pressing out as much of the contained gelatinous material as possible, and religates

it with a silk ligature that has been rendered thoroughly antiseptic by being boiled in a strong solution of corrosive sublimate and afterward kept in a solution of iodoform in ether. The cord is then dressed with a piece of sterilized gauze, covered again with a pad of gauze soaked in chemically pure glycerin, and the whole retained by a sterilized flannel bandage. Each day the pad is removed and a fresh one, soaked also in glycerin, applied; as often as the retaining band becomes soiled it is changed."

Some months since an obstetrician and writer of much merit, published a paper, in which not an earnest plea, but pointed or-

ders were given to every physician who expects to be called to a case of labor, "to visit the patient at least three months before the expected time and make a careful *per vaginam* examination and an external abdominal one, to see if there are defects in the genital organs, or wrong position of the child to be corrected; and that these visits and examinations should be repeated at short intervals until the labor is near at hand." I have neglected to mention an inquiry and examination to which he referred; namely, "to ascertain the condition of the kidneys; whether or not there are threatenings of Brights Disease." All these visits and examinations are to be made by a doctor rendered thoroughly antiseptic from head to toe.

Now, while I consider this unasked—for interference, this securing a patient and loading her with a heavy medical bill, wholly unjustifiable, there is even a weightier objection to it. It frightens the patient. So earnest is the doctor, so positive are his objections, so frequent his visits, so alarming the fact that the urine must be so often examined, that the poor woman's fears are excited to a degree that makes her nervous and unhappy, when she otherwise would have gone on from day to day hopeful and joyous.

But you ask, "Why drag this subject into a review or criticism of the paper of Dr. Allen?" Simply because we are throwing around the natural and successful process of labor, requirements not needed in more than one case in fifty—if, indeed, so many as one—and because in cities—medical centres—women are made unhappy by such interference, such prognostics of danger if they do not strictly observe all the physician's details.

Now, about the care of the cord. This is a proper subject to think about. Dr. Allen has, yet, something to learn. I infer that he ties the cord directly after the child is born, cuts the cord and then hands the child to the nurse. Years ago, between 1860 and 1870, some of the members of our County Society, instead of tying the cord, cut it at once and let the blood fly—as it sometimes did to a distance of several feet. When it ceased to bleed, some left it without tying, while others, fearful that it might possibly bleed, secured it by a common thread ligature. My mind being thus called to the subject, I felt that it was wrong to spill so much

of the blood that belonged to the child, and I resolved to see how much would be lost by cutting, or, which produced the same result, tying it soon after its birth, as seems to have been the habit of Dr. Allen. To ascertain how much blood is lost to the child by cutting the cord soon after the child is born, I (Case 1.) cut the cord of a healthy male child three inches from the navel, in two minutes after it was born I caught two ounces of blood from the cut end of the cord.

Case 2.—Female; caught two ounces in three minutes.

Case 3.—Male; caught two and a half ounces.

Case 4.—Male; caught slightly more than two ounces.

In every case there were more than two ounces, for I first caught it in a bowl and then poured it into a graduated glass. In doing this, some adhered to the bowl and some was lost.

Is it a matter of indifference whether the child is robbed of this blood or not? How is it disposed of in a natural case when the doctor is not present? It flows from the umbilical vein without hindrance into the body of the child; the cord collapses by a natural contraction; generally within a half an hour the pulsation of the umbilical arteries cannot be felt in the umbilicus of the child, and the cord, white, flaccid, shrivelled and without a drop of blood in it, lies before the observer. Here is where Dr. Allen, by tying the cord, is doing wrong. Had he let the cord alone until the pulsations had ceased, he need not have squeezed out any gelatinous matter. A child thus treated is in no danger from hemorrhage. The small, flaccid, bloodless cord dries and falls off in a few days, without a drop of pus being formed, without need of aristol or gauze pad—much to the disgust of the microbe—and without the officiousness of the obstetrician.

In the transactions of the Pennsylvania State Medical Society for 1872, I have reported thirty-four cases in which I observed the time during which the pulsations of the umbilical cord could be felt in the vagina before the placenta was expelled, and for how long a time they could be felt at the navel of the child. The circulation of the blood continues in the placenta until it is separated from the side of the womb, and even in cases where the

placenta quickly follows the child, the circulation may go on for many minutes. After a short time the arteries of the cord fail to force the blood to the placenta, and gradually the blood recedes until the pulsations cannot be felt in the stump—the projecting umbilicus. For many years, in view of these facts, I have waited before tying the cord until the blood in the vein had all passed into the child and the contraction of the arteries, beginning at the placenta, had gradually prevented the blood from the child's heart being forced into the arteries of the cord. I have, therefore, needed no antiseptics, and the fiendish microbe was not to be seen in that region.

I know by actual experience from repeated trials that, if the cord be not tied until after the blood has passed from the umbilical vein into the body of the child, not a drop of blood will escape from it if, afterward, it be not tied.

In view of these facts physicians should have patience; should allow a few moments to pass before tying the cord. Then they would see the cord which was turgid with the fullness of blood, lying empty; a white, flaccid, shrunken thing, which may be cut without fear of a single drop of blood coming from it. If when you take hold of the stump, as I call the then fleshy projection, the pulsations of the ar-

teries can be felt between the thumb and finger, one must wait a little longer—and when this cannot be felt, one will then know that there is no danger of bleeding from the cord.

If it be important in this attention to the woman to insure her safety according to Dr. Allen, and so important in the opinion of the other writer that such elaborate measures as washing the child's belly with corrosive sublimate solution and using gauze pads, etc., be needed to avoid ulceration of the navel of the new-born child, why shall not the accoucheur give a few minutes of time to waiting for the blood to get into the child's body, when it will be secure from hemorrhage or having a sore navel.

It is painful to me to see enlightened physicians, even teachers of obstetrics, carrying on the old plan of tying the cord instantly after the birth of the child, when waiting for a short time would obviate the need to tie it at all.

I need not comment on the wrongfulness of these numerous measures and the danger of these washings with the poisonous corrosive sublimate solutions. The fact that millions of children born in our country every year do well without such measures must prove the impropriety, needlessness and danger of them.

CHRISTIAN SCIENCE AND MEDICINE.*

J. N. HUNSBERGER, M. D., SKIPPACK, PA.

It is a well-known fact that primitive man from time immemorial has allowed his thoughts and actions to be governed by the supernatural. The changes from day into night, the different phases of the moon, eclipses, storms, droughts, floods, in fact all changes that followed nature's laws were to him the display of the love or anger of whatever supernatural being he chanced to worship. And the cannibal, who to-day prostrates himself before his pile of stones, worships his god no less intensely or devoutly than does civilized man under the highest enlightened conditions of society. The difference is in environments,

not in degree. The savage is satisfied with what seems an answer to his petitions, in the gratifications of his few wants. Civilized man is usually dissatisfied because all his petitions are not answered.

Huxley tells us, "suffering came into the world, not in consequence of a *fall*, but of a *rise* in the scale of being; so every further rise has brought more suffering. The amount and severity of the pain, no less than the variety and acuteness of the pleasures, have increased with every advance in the scale of evolution." Just as the highly sensitized plate of the camera reproduces quickly and accurately any impression made on its surface, so does

*Read before the Montgomery County Medical Society, May 9, 1894.

the exquisitely sensitive nervous gray matter of the highest grade of enlightenment reflect impressions, quickly and acutely, that cause pain or pleasure as the case may be. That we are steadily rising, steadily evolving, no one can successfully dispute.

Let us quote again from Huxely: "The doctrine of evolution implies indeed a former state of innocence of mankind, but it is the innocence of the ape and of the tiger, whose acts, however they may run counter to the principles of morality, it would be absurd to blame. It is a reasonable supposition that in the earliest human organisms an improved brain, a voice more capable of modulation and articulation, limbs which bent themselves better to gesture, a more perfect hand, capable among other things of imitating form in plaster or other material, were combined with the curiosity, the mimetic tendency, the strong family affection of the next lower group."

But in spite of this mental and physical evolution we are, so far as our emotions and beliefs are concerned, not so distantly removed from the lower strata of mankind. We still believe Friday to be an unlucky day. We have not forgotten the superstition of the first glance at the new moon. We still pay our good dollars to be cured by quacks. We still believe the testimonials of wonderful cures effected by taking one bottle of somebody's patent medicine. We still go to Paris to be hypnotized or to be inoculated for hydrophobia. We still believe, as they did in the time of the Pharaohs, that charms, incantations and amulets will drive away all aches and pains, if only these charms, incantations and amulets can be called "by any other name."

"But faith, fanatic faith, once wedded fast
To some dear falsehood, hugs it to the last."

There is something so pathetic, because so intensely human, in the blind belief that draws thousands and tens of thousands of suffering humanity to pay homage to the Grotto of Lourdes and bathe in its holy waters. That thousands are temporarily relieved or permanently cured, the numerous crutches that decorate the walls of the grotto testify. When even royalty tramp about in the morning dew with naked feet, guided by an ignorant monk, we can to a certain extent sympathize with some of the superstitions of the less educated class-

es. Or, when such men as Brown-Sequard, with his expressed juice of the testicle, attempts to inject new life into the wreck of a man, we are forcibly reminded of "when all others fail consult Dr. Snobb." Or, when Hammond, with his compressed extracts of brain, liver, lungs, ovaries, etc., attempts a cure by giving some of the hair of the dog that did the biting. Or, possibly, when Pasteur and Koch, with their lymph and hyperdric syringe—but why give you post-mortems. And yet these men represent the best in medicine, stand at the very top of the profession. "They do bestride the narrow world like a Colossus, and we petty men walk under their huge legs, and peep about to find ourselves dishonorable graves." They have thrown out a tempting bait; they have been rewarded with a nice string of suckers—more than a nibble.

It is the insane desire for something new, some royal road to success, that leads so many investigators to make misleading statements, arrive at false conclusions. The people demand something new in all the arts and sciences, and usually get it—such as it is. The press caters to this unnatural appetite; all sorts and conditions of men furnish the food, and there you are. Take your choice—hypnotism, hoodooism, faith cure, christian science. They are all practically the same; they have one common end in view. And so long as "faith is a higher faculty than reason," just so long will they create new diseases and invent new cures. "Even the earnest Charcot was accused of manufacturing new types of invalidism by his scientific performances at the hospitals, while some common doctor will rescue case after case by using methods which are not medical, but pedagogic and moral."

There is nothing new about christian science except its name and a few little details that are made to stand out so prominently as to conceal the identity of the old-fashioned faith cure. Christian science claims that the body should be at all times subservient to the mind; that if the mind wills it strong enough, the whole army of micro-organisms which are claimed to be the cause of infectious diseases, will be unable to gain entrance to the body. In fact it makes the human organisms a more impossible culture medium than a saturated solution of bi-chloride of mercury. As a lecturer

on christian science answered, in reply to the question, "What would be the effect on a person of a highly poisonous dose of strychnine?" "If the individual who took the dose had enough faith, the poison would be harmless." But, the lecturer added, it would require years of training in the art of christian science before the person would have faith enough to stand such a test.

This is simply absurd, and yet it is not any more absurd than some medical fads that have had a following in their day. The trouble is the pendulum has swung too far. Just at present, the awful danger of contracting phthisis has become the fad, and precautions, as ridiculous as they are unnecessary and annoying, are heaped on the stricken ones.

That christian science has a following of some of the most intellectual people, is uncontroversial. It is a truth, that as we advance in the scale of enlightenment we still cling to the supernatural, but we demand that our ghosts come to us dressed and in their right minds. As Thomas Carlyle, in *Sartor Resartus*, so aptly puts it, "Witchcraft and all manner of spectre-work and demonology, we have now named madness and diseases of the nerves, seldom reflecting that still the new question comes upon us: What is madness; what are nerves? Was Luther's picture of the devil less a reality, whether it was formed within the bodily eye or without it? In even the wisest soul lies a whole world of internal madness, an authentic demon empire, out of which, indeed, his world of wisdom has been creatively built together, and now rests there, as on its dark foundations does a habitable flowery Earth-rind."

Every thinking medical man must realize that we are tending slowly but, nevertheless, surely, to therapeutic measures that have as their basis of treatment the patient's mind itself. I refer principally to morbid nervous troubles, of which we know but little. Just what these therapeutic measures should be is as yet undiscovered, but that potion and pill will enter into their makeup, I do not believe. They will have a great deal of opposition. "We are, as was Ephraim of old, wedded to our idols; we want to be let alone." We prefer to see our fellow beings suffer than to see them cured in an irregular way. We can't un-

derstand how an ignorant quack can cure (?) hydrophobia, while the scientific Pasteur loses 25 per cent. of his cases.

I believe that in the near future there will be a chair of psychology in every medical school in the world, where the best methods of securing control of the patient's mind will be taught. It will open a field hitherto undreamed of in the science of medicine. For if ignorant, uncultured charlatans can effect such wonderful cures, what may not be accomplished with the best minds of the medical profession directed to the subject. And what a training will be necessary for the scientific faith cure; what a study of mankind; what an opportunity for the development of individuality, and what a pleasure to know that your patient's mind is to you an open book, on whose pages you may inscribe the way to health.

Antiseptic Ointment.

After delivery in placenta prævia Dr. Q. C. Smith is in the habit of applying to the external genitalia:

\mathcal{R}	Olei pini pumilionis.....	
	Olei sassafras.....	
	Olei Camphor.....	3ij
	Olei cinnamon.....	3j
	Sacchar. alb. in very fine powder.....	3iv
	Lanolin.....	3viij

Mix well and make ointment.
Sig.: Apply as directed.

—*Virginia Medical Monthly.*

For Chronic Catarrhal Diarrhœa.

\mathcal{R}	Extract of rhatany.....	1 drm
	Syrup of morphine.....	
	Syrup of quince, each.....	12 drms
	Lime-water.....	q. s. to 5 ounces

\mathcal{R}	Liq. perchlor. of iron.....	8-15 grains
	Sydenham's laudanum.....	20-30 drops
	Mucilage of gum arabic.....	
	Simple Syrup, of each.....	1 ounce
	Cinnamon distilled water.....	q. s. to 5 ounces

Sig.: Dessertspoonful every two hours of either of the last two mixtures.

—*Ther. Gazette.*

Diarrhœa.

Sapelier presents the following formulæ:

\mathcal{R}	Lactic acid.....	5 drachms
	Simple syrup.....	6 ounces
	Boiled water.....	1 quart

\mathcal{R}	Subnitrate of bismuth.....	8 ounces
	Carbonate of calcium.....	
	Phosphate of calcium.....	
	Powder of rhatany, of each.....	2 ounces
	Powder of crude opium.....	45 grains

M. Sig.: Two or three dessertspoonfuls a day, given in the lactic-acid solution.

COMMUNICATIONS.

LAPAROTOMY FOR RELIEF OF INTUSSUSCEPTION; WITH REPORT OF A CASE OCCURRING IN A CHILD ÆT. NINE MONTHS .

W. O. ROBERTS, M. D., LOUISVILLE, KY.

On Tuesday, April 26th, at 12.30 p. m. I was called by Dr. Turner Anderson to do a laparotomy for intussusception. Dr. Henry Heuser, who happened in my office as I was starting, accompanied me. On reaching the house, we learned from Dr. Anderson that he had seen the case for the first time at 11 o'clock, and after a fruitless attempt to reduce the intussusception he advised a laparotomy and telephoned for me. The child had been sick since the Friday morning preceding our visit.

The child was nine months old, a girl, had always been perfectly healthy and was well developed. The attack came on suddenly without any assignable cause. It presented the usual symptoms, viz., intense paroxysms of pain, frequent straining at stool with passage of blood and mucus, and frequent vomiting. The intussusceptum extended to the anus, and was very deeply congested. A sausage-shaped tumor could be distinctly outlined in the left side of the abdomen; the abdominal cavity was but slightly distended. The intussusceptum could be pushed up as far as the finger would reach with perfect ease. While going under chloroform the straining effort forced the intussusceptum two inches outside the anus. As before stated it was quite deeply congested, but no ulcerations or excoriations were detected.

Notwithstanding the feeble condition of the child's heart, a laparotomy was performed. The abdomen was quickly opened in the median line between the umbilicus and symphysis, and the tumor was found a little below and to the left of the umbilicus. After gentle traction assisted by Dr. Anderson pushing from below the intussusception was relieved. It proved to have started at the cæcum, which had extended clear through the colon and the rectum taking with it the ileum and its mesentery. No injury was done the gut

in the operation and it seemed to be in good condition after the intussusception was relieved. The child became pulseless during the operation and a number of hypodermatic injections of whiskey were given. It was on the table only about twenty-five minutes. After being put to bed it was given morphine and atropine hypodermatically, and for a while rallied considerably, but finally began to sink and in a few hours, like the majority of such cases, it died.

In looking over history of intussusception I find that according to Treves three-eighths of all cases of intestinal obstruction are due to intussusception. Hensner puts the proportion at three-fourths. The American Text Book of Surgery says thirty per cent., excluding cases due to herniæ and malformations, and Moullin estimates it at about one-third. Fifty per cent. of the cases occur in children under the age of ten years, and twenty-five per cent. in the first twelve months of life. Eustace Smith says that obstruction is rarely due to any other cause in children. Of fifty-two cases collected by J. Lewis Smith, thirty-one occurred during the first year of life. Hare, in his late work, says it is the commonest of all causes of obstruction, and during the first year of life it is more common than all the other causes combined. After the age of five years it becomes comparatively rare until the fortieth or fiftieth year, when it again increases in frequency of occurrence. During the first year of life it is met with more frequently in boys than in girls, in the proportion of about three to one, but as the age increases the relative disproportion gradually diminishes. Under twenty months of age those that are attacked are usually sturdy and well nourished children, while in older ones it is more frequently met with in those that are run down in health from some intestinal disorder.

Rilliet attributes this comparative frequency in infants to "the looser connec-

* Read before The Louisville Medico-Chirurgical Society.

tions of the cæcum in the iliac fossa at this age, and also to the imperfect development of its muscular bands which lessens its resistance to the penetration of the small intestine into its interior." J. Lewis Smith, I think, gives about the best explanation of the comparative frequency of the disease in children. He says "it is due partly to the anatomical character of the intestines in this period of life, and partly, doubtless, to the fact that there are more frequent irregularities in the intestinal movement than in older children. In fact the walls of the intestines are thin, the mucous and muscular coats and the connective tissues being much less developed than in those that are older; the mesentery and the meso-colon have also greater depth as compared with the same in other periods of life, except the meso-colon at the points where it passes over the kidneys, in which places it is very short, or even in some cases nearly absent. Moreover the space occupied by the large intestine, in which part of the digestive tube intussusception commonly occurs, is shorter relatively to the length of the intestine than in those that are older." In about thirty measurements which he has made of the length of the large intestine and the space occupied by it, the latter was found in the average about one-third that of the former, which, of course, necessitates doubling of the intestine on itself.

The varieties as to location are ileo-cæcal, where the cæcum and ileum are turned into the colon; ileo-colic, where the ileum passes through the ileo-cæcal valve and finally brings along with it the colon; the colic, in which the colon alone is involved, and the enteric, where the invagination is located entirely in the small intestines. The ileo-colic is by far the most frequent. Treves says about seventy per cent. of all cases in babies are of this variety. After invagination takes place, peristaltic movements are excited and the intussusceptum is pushed farther and farther until frequently it protrudes through the anus.

In the case reported by Harrison Cripps (*Lancet*, June 2nd, 1888), "the patient, a child seven months old, was admitted to the hospital with the bowel in a gangrenous condition, protruding from the anus. It sloughed away gradually, and at the end of a month the case was discharged

cured. The child afterward died of scarlet fever, and at the autopsy the small intestine was found attached to the anus. There were no traces of the ascending, transverse or descending colon."

In about one-half of the cases the children are in perfect health and the attack come on suddenly without any assignable cause. Most authorities claim diarrhoea, colic, tenesmus from any cause as constipation, polypus, phimosis, etc., play a considerable part as etiological factors. Jacobi and others deny this. Some cases seem traceable to falls. Jacobi reports one case that was produced apparently by a child being jumped up and down in it's nurse's arms.

SYMPTOMS AND TREATMENT.

The symptoms usually come on suddenly and with great violence, especially is this the case when invagination occurs at the ileo-cæcal opening. The symptoms are much less severe when invagination is located in the colon. Pain is paroxysmal in character, due to the irregular peristaltic action of the bowels, and the paroxysms steadily increase in frequency and severity. Vomiting is a prominent symptom, not so marked, however, as in strangulated hernia, in the beginning of the attack, but after a while it becomes very marked. The abdomen at first is not tender, and slight pressure seems to give comfort to the patient; after a while when inflammation occurs, of course it becomes exceedingly sensitive. It is not always distended. In the beginning of the trouble there is not complete occlusion and the consequence is that distension is not marked, but after swelling takes place the lumen of the protruded portion becomes obliterated, then distension becomes very marked. In these cases, if not relieved, inflammation occurs and in a small proportion sloughing of the intussusceptum takes place, and in cases where this does occur, about forty-one per cent. recover. Many of these, however, afterward die from perforation of the cicatrix. A tumor can be detected usually in about one-half the cases. The prognosis is very bad.

In the American Text Book of Surgery it is claimed that about eight per cent. of the cases treated medically die. Treves gives the mortality in 133 recorded cases, where radical operations were performed, as seventy-two per cent. When reduction

was easy, it was thirty per cent., and ninety-one per cent. when reduction was difficult. Hare, in his work, gives the mortality seventy-four per cent. when the cases were treated medically, and seventy-five and four-tenths per cent. where abdominal section was done. In most cases where abdominal section has been performed, the cases have been treated for quite a while by medical means and, of course, it does not give the surgeon a proper showing. I have no doubt if early operation was performed that the mortality would be much less.

The medical treatment consists in the use of opium and belladonna for the purpose of relieving pain and quieting peristalsis, then endeavoring to overcome the intussusception by injections and insufflation. Injections should always be used early in the case. If it is deferred until inflammation occurs, until the intussusception becomes fixed, then I believe it is exceedingly dangerous, the danger being over-distension and rupture of the gut. The same thing will apply to the use of insufflation. Some authorities recommend that injections be used without anæsthesia, so that it can be told by the sensation of the patient when there has been sufficient water thrown into the bowel. At the same time they recommend that insufflation be used under an anæsthetic with the patient in the inverted position. After a trial of these means for a short time with negative results, then operative interference ought to be instituted at once.

The best point of doing a laparotomy is in the median line. It is usually not difficult to reach the intussusception by this incision, but if this cannot be done, it is a very easy matter to make an incision directly over the seat of the tumor. Great care should be taken in overcoming the invagination; by pressure upon the gut you can empty it to a certain extent of its distended blood vessels, then by careful pressure upon the protruding portion from below, as was done in the case I operated upon, you can usually overcome the invagination without much difficulty, provided inflammation has not occurred and adhesion of the serous surfaces taken place. When this has occurred they may be broken up usually by the use of a probe.

Where we fail to relieve the invagination then it becomes necessary either:

First—To make a lateral anastomosis above and below the intussusception; or,

Second—To resect the affected portion of the gut and make an end to end anastomosis; or,

Third—To make an artificial anus.

The mortality is always very much greater where the trouble occurs in the young.

Cor Adiposum.

Schott (*Deut. med. Woch.*) observes that, although there are no certain signs of this condition, there are several symptoms, such as the general state of the patient, the condition of the heart sounds, rhythm, etc., which makes the diagnosis very probable. Often this fatty deposit in and about the heart cannot be distinguished from fatty degeneration. The author gives some account of the physical and dietetic treatment of the disease. The object of the dietetic measures is to diminish the amount of fat. There is no means of making collections of fat disappear from certain parts of the body. The fat round about the heart disappears last in starving animals. Thus the improvement in the patient's condition cannot be brought about in this way. Purgative measures are harmful, and the doubtful effects of iodides are often further obscured by other symptoms produced by them. If anæmia, diabetes, gout, and especially arteriosclerosis, be present, dietetic treatment must be adopted with great caution. Any considerable loss of weight must be carefully guarded against. Patients, who have lost weight in consequence of treatment by mineral waters and dietetic restrictions may develop signs of cardiac weakness. As regards limitation of fluids, the amount of alcoholic beverages must be lessened. It is probable that the loss of weight which may occur when fluids are diminished is really due to the impaired appetite. The author's methods of treatment consists in methodical exercises, bath treatment, etc. He thinks his treatment may be carried out with benefit, and without the risks attending other methods recommended. He quotes cases to show that unpleasant symptoms may be removed without the patient losing weight. It is only when the heart has gained strength and is not to be distinguished from a normal heart that any thinning treatment should be adopted. Any rise of temperature is also a contraindication to it. Moderate exercise in the fresh air, which may be increased later, is useful, but over-exertion may produce unpleasant symptoms.

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SATURDAY, SEPTEMBER 29, 1894.

EDITORIAL.

NEGLIGENCE.

The physician, more than any other professional man, is sensitive to criticism. This is due, probably, to the peculiar characteristics and relationships of his profession, to the high standard of individual qualifications which must be attained to deal with the many complex issues involved in practice, to the varied and strong competitions with which he must contend, and to the jealousies with which he must combat—jealousies multifarious in expression, sometimes creditable, generally discreditable.

Zeal for mastership in the profession grows with the ever widening domain of its science and art, and with the equally progressive intelligence of the people. Possibly this zeal receives no slight stimulus from the increasing difficulty of taking, in the character of a quack, refuge from the consequences of practice as a professed physician.

Diligence may justly be claimed as one of the salient merits of the great body of the profession; yet negligence may occur with the overworked physician as well as the underworked, indolent or indifferent, though for very different reasons. But

errors and negligences are closely scrutinized and receive but little sympathy either popular or judicial.

The tests of what a man knows in his professed art or science may not be those of scholastic refinement, but the tests of his practice are chiefly those of the fidelity with which he applies what he knows; the simple tests of professional and moral duty. There is no continuous duty in which one can engage without, at some time or other during its discharge, becoming liable for negligence. By its very limitations, the human mind is incapable of perfect diligence. The chief danger is that diligence may become intermittent.

Two kinds of neglect must be borne in mind—negligence in commission and negligence in omission. The niceties of distinction between the two is of little moment here. It is the sequence, the mischievous consequences, the natural and probable results of the negligent act or omission that are of vital concern.

The legal liability of a physician comes under the same rules that govern in matters of the business expert generally. He is obliged in each case to apply such

diligence as good physicians, called under similar circumstances, are accustomed to apply. Negligence, as interpreted in civil relations, is an "inadvertant imperfection by a responsible human agent in the discharge of legal duty, as produces in an ordinary and natural sequence, a damage to another." The inadvertancy or want of due consideration of duty is the injury.

No general rules can be laid down as to what constitutes negligence. To make the physician liable, his negligence must stand in immediate causal relation to the injury. The diligence of the physician must be more than that of common-sense. It must be the diligence of science and skill. A person who, without special qualifications, is called upon to attend a sick person, is expected to apply such diligence only as is bestowed in such cases by persons of ordinary common-sense, and is liable only for failure in such diligence.

As a rule, the degree of diligence required is proportionate to the duty and responsibility imposed, and the degree of negligence imputed corresponds to the degree of diligence exacted. In each case, negligence is the failure to bestow the care and skill which the situation demands.

It is conceded that the negligence of the specialist varies with the nature of the specialty and the intensity of the duty. The skill of the specialist must be that which he usually employs; he must show himself an expert in the particular branch with which his reputation associates him—if an oculist, he must show himself an expert in his specialty; he must exercise a greater amount of skill and care than is implied by the word ordinary. For a person without the necessary qualifications to undertake a business requiring skill, is itself an act of negligence, causing damage but not implying an intent to injure. The surgeon who undertakes an operation for which he has not the proper qualifications, is liable for the damages his unskillfulness works.

Diligence should extend to those having the care, nursing and management of the patient. Neglect of such often involves the physician in trouble. There may be no liability, yet culpability. But there exist not a few instances where legal liability has been found on the part of the physician, where there was mismanagement or neglect on the part of those having charge of the case. Cases of this character stand, by analogy, upon the same ground with a common class of cases—*e. g.* an action for the recovery of damages caused by alleged defects in highways. The liability of the town is established, the injury proved and the resulting effects become the subject of inquiry. Whereupon the town claims and endeavors to prove that, owing to mismanagement or negligence in treating the injured party, the consequences have been aggravated. Such showing on the part of the town does not touch the cause and right of action, but the measure of the damages only.

There may be negligence as to instructions needful to be given patients. It has been held by the courts that a physician who had attended a broken limb, was liable for injuries resulting from failure to give instructions as to the use of the limb after the patient's discharge.

A patient under treatment may injure himself, yet he may recover of the physician if the latter carelessly or unskillfully treats him afterwards, and thus does him a direct injury. It must be remembered that there are few ailments in which the patient may not be charged with more or less negligence.

There is a negligence that grows out of over-anxiety or of timidity. It is a factor in many accidents and injuries, and is a frequent cause of fatal results. Lord Macaulay has illustrated this aptly:—"Queens, it has often been said, run far greater risk in child-bed than private women, merely because their medical at-

tendants are more anxious. The surgeon who attended Maria Louisa was altogether unnerved by his emotions. 'Compose yourself,' said Bonaparte, 'imagine that you are assisting a poor girl in the Faubourg Saint Antonio.' Bonaparte knew mankind well; as he acted toward the surgeon, so he acted toward his officers." Knowledge, skill, nerve, dexterity and diligence are the requirements.

It is good law, and sound reason as well, that more should be required of the specialist than of the non-specialist. He must put into his work what he professes to the world. It must show in his results. He must possess fertility in expedients, and promptness and intrepidity in applying the right remedy, at the right moment and in the right way, to the right thing.

As Mr. Huxley succinctly states it;—"There is really only one way of ennobling any calling, and that is to make those who pursue it really masters of their craft, men who can truly do what they profess to be able to do and what they are credited with being able to do by the public. And there is no position so ignoble as that of the so-called liberally educated practitioner who, as Talleyrand said of his physician, 'knows everything; *even a little physic*,' who may be able to read Galen in the original, who knows all the plants from the cedars of Lebanon to the hyssop upon the wall, but who finds himself with the issues of life and death in his hands, ignorant, blundering and bewildered, because of ignorance of the essential truths upon which practice must be based."

ABSTRACTS.

TUBERCULOSIS IN CATTLE.

[The results of investigations dealing with the serious question of tuberculosis in cattle from both economical and sanitary standpoints are embodied in an important report of the Agricultural Department prepared by Dr. Theobald Smith, chief of the Animal Pathology Division. The report in part is as follows:]

In making tests the temperature of the inspected animal should be taken every two hours, at least six or seven times before making the injections. The most convenient place for an injection is the side of the neck where the skin is thin, and a large strong needle gives much more satisfaction than a small, fine one. Seven or eight hours after the injection the temperature should then be taken, and from then on every two hours until a decided reaction, continuous during several hours, has occurred, or until eighteen or twenty hours have passed since the time of the injection. To attack tuberculosis as it exists at present, is a most difficult problem, and no single measure, however sweeping, is likely to be successful. The present wide dissemination of the disease,

and its prevalence among other domesticated animals, as dogs, cats, horses, and, above all, its prevalence among man, makes the complete extinction of the malady an unrealizable problem. Infection through the air is the most serious problem to be dealt with. A question of such practical consequence is the effect of repeated infections. That cattle may be infected more than once is self-evident. The more frequent infections the more rapid the disease and the speedier the danger to other animals. The fewer the tubercle bacilli in the air, the more reduced the danger. It is highly probable that cattle may, under conditions, inhale a few tubercle bacilli without permanent injury. The importance of reducing the amount of infection in a herd by all possible means, and keeping it permanently reduced, is one necessary condition for the successful eradication of tuberculosis.

Primary infection through the air is more frequent under existing conditions than any other mode of infections; early stages of the disease may consist of glan-

dular affections only; extent and rapidity of the disease depends at least in part upon the number of tubercle bacilli inhaled either within short or long periods of time; tuberculosis of the lungs is not necessarily associated with any other recognizable lung affection as a pre-existing favoring condition. Tuberculosis of the liver is probably in most cases a result of food infection. Tuberculosis of the membrane seems to cause less damage to the animals affected. It takes place principally by escape of bacilli from some forms of the disease situated under one of the serum coverings, as lungs, liver, intestines and associated lymph glands. It does not appear probable that organs are invaded to any extent by tuberculosis starting on their serum covering. The tubercle bacilli appear to be usually carried in lymph channels with the current, but a case of evidently retrograde movement of the bacilli has been noticed. The virus of tuberculosis does not vegetate in the blood, its presence there being accidental. In the more advanced stage of the disease infection of the blood may occur repeatedly. Generalized infection may be recognized by the discovery of disease in organs not accessible to the virus in any other way than through the circulation or in the lymph glands of such organs. Tuberculosis of the subcutaneous lymph glands and of those situated in the muscular tissue of the trunk and limbs, is universally accepted as indicative of the generalized disease. Such glands may be infected from without, but infections through wounds in the skin are quite rare. Generalized infection, both chronic and acute, has obtained considerable attention owing to its important bearing on the infectiousness of meat and milk. In all cases of generalized disease the milk should be regarded as dangerous. The difficulty, from the practical standpoint, lies in the recognition of the generalized infection during life. With the meat the question is simple and resolves itself into thorough inspection of every carcass at the abattoir by trained inspectors, and with the living animal there are only a few guides, such as the conditions of the udder lymph glands or fragment of some superficial lymph glands.

The region of the throat and of the small intestines are more likely to absorb tubercle bacilli early in life than later on,

while the lungs seem to become, with age, the preferred seat of the disease. Demonstration of this assumption is complicated by the fact that calves are more exposed to food infection than adult animals, because of the dangers of tubercle bacilli in the milk. There is every reason to believe that most of the tuberculosis of cattle is not demonstrated at or before birth, but is contracted by contagion later on in life. Cattle owners should pay special attention to the condition of udders, a disease which is particularly dangerous because the milk at first appears normal for some weeks, and, therefore, would be used with impunity. With this disease the only danger to other herds lies in direct contact or in the transfer of a diseased animal or of milk from such an animal. The greatest danger exists in the immediate surroundings of the infected and loses itself as the distance increases. In order to control any infectious disease it is of the utmost importance to recognize in the living animal not only advanced stages, but even the slightest infection. It is essential that the tuberculin test be repeated not later than after an interval of six months, so as to reveal cases not detected at the first test. Cattle owners should become familiar with the general nature of tuberculosis, thereby lifting themselves above the plane where quackery and specifics abound, and understand precisely what to expect after the disease has entered the herd, and how to meet the demands of public health. Sanitary precaution should begin the removal of diseased and suspected animals. The investigations show that the milk of tuberculous animals is not so frequently infected as supposed.

Milk of animals in the earliest stages of the disease, and with perfect udders, does not contain tubercle bacilli. Only those showing signs of labored breath and emaciation should be gravely suspected and their milk excluded at once from sale.—*Public Opinion.*

Tania.

Dr. Descroizilles prescribes the following mixture:

R	Ethereal extract of male fern.....	5ij
	Calomel.....	gr. vj
	Peppermint-water.....	5iiss
	Gum arabic.....	3i¼
	Simple Syrup.....	5v
	Distilled water.....	q. s. ad. 5ij—M.

—*La Medecine Moderne.*

A NEW THEORY OF THE NERVOUS SYSTEM.

Every one knows that the nervous system seen under the microscope, whether it be a question of the brain or the marrow, consists of two principal elements. The first of these elements are the long fibers, the thin threads, placed side by side in great numbers and in a very particular manner. These threads appear to play the part of conductors: they connect the marrow to the brain, the different parts of the brain to each other, or they form the nerves, connect the muscles to the marrow, or place the latter in communication with the sensitive organs: the organs of touch, of the retina, of the internal ear, of taste, of smell. These threads serve to transmit shocks, vibrations, from one part of the nervous system to the other; they are like telegraphic wires which transmit the current from a distance; they are the advance routes, the roads of communication.

The elements of the second group are physiologically higher. They are composed of the nervous cellules. These cellules form the essential part of the nervous centers; it is the cellules which are met by the conducting threads, and the nervous cellules have from all time been considered as centers, as points from which are developed the modifications, the vibrations, of which the nervous fibers are finally made the vehicle. The nervous filaments have the form of threads; the cellules are little bodies of irregular form which, from their angles, send out a certain number of very fine fibrils. For a long time, histologists have been trying to find out the exact relation of the cellules with the threads and the cellules with each other. Not long since, an Italian, Golgi, gave us some very important information on certain sides of these questions. He discovered a method of coloring which permitted him to separate certain elements, so that some of them remained uncolored, and in this way he showed that the fine network of fibrils which surrounds each nervous cellule is furnished, not with a protoplasmic substance, but with elements of a purely nervous structure which are subdivided in proportion as they are removed from the cellule. There is a network of protoplasmic prolongations, but these are not connected with those of the

neighboring cellules: they have a free termination, most often in the vicinity and in contact with the capillaries, and represent a system of roots, by means of which the cellule is nourished with the contents of the capillaries. They are not at all nerve conductors.

These views of Golgi at first created great surprise, for they made the cellule simply a sack of nutritive moisture. It must, however, be admitted that these views are exact. A Spanish scholar, Ramon y Cajal, has completed these experiments in a very comprehensive manner. He has furnished us with a very clear idea of the true relations of the cellules. Each of these forms an apparatus, giving birth to two orders of fibers. Some of these are centripetal or cellulipetal, and form a passage for the vibrations coming to the cellule from without; the others are cellulifugal, and serve as passage ways for the vibrations going out from the cellule. The first are the protoplasmic filaments; the second are the threads or fibrils of the nervous structure. The two elements of the network surrounding the cellule have then two different functions: by means of one the nervous vibrations arrive; from the other, they depart. But the principal fact made manifest by Ramon y Cajal is that there is no continuity between the two orders of fibers. The cellulifugal fibers of a given cell do not mingle with the cellulipetal fibers of a neighboring cell as was formerly believed: there is only proximity and contact. This amounts to saying that there is no fixity or immutability of the network of communication between cellule and cellule: a vibration does not necessarily pass by a pre-established way. This is of the greatest importance, not only from an anatomical point of view but still more and above all for psychology, heredity, education and conduct. It is a well-known fact that no first performance of anything is satisfactory. But in what does this work consist? In forming, establishing a way of communication. If the fibril network were fixed, if the ways were pre-established, work would be easy, and it would be difficult to comprehend why exercise renders frequent operations so easy to transmit until finally they become almost

automatic. But from the moment we find the ways are not fixed, and that they are only established by repetition and exercise in a more or less different manner for each individual, and that several ways may be formed, everything is explained. If the habitual way is obstructed, a new one may be formed; the vibrations take a different road, but reach the same goal. We then have an anatomical base for the well-known differences shown by different individuals with regard to the acquisition of any talent, no matter what. The capacities, the predispositions are deter-

mined by the anatomy of the structure, predispositions which may be purely physical, intellectual and even moral. We must then change our conceptions with regard to criminality and morality. We owe to the refractory elements of society more pity, more humanity, but we have less hope of drawing them from the condition in which we find them. I have only attempted to indicate the questions which are raised; but it is enough to show in what distant domains this work of Ramon y Cajal finds its echo.—*Henri de Varigny in the Paris Revue des Revues in Public Opinion.*

TREATMENT OF ACUTE AND CHRONIC ULCERS.

Dr. DeCoursey in the *Louisville Medical Journal* writes:—

I have found no classes of diseases yielding to treatment with greater reluctance than "old sores," or chronic ulcers. Recently, however, I have adopted a plan of treatment which is quite different from that laid down in the books, and my results have been much better.

Almost without exception, internal, or constitutional, as well as local treatment, is necessary.

The internal treatment should be directed to the seat of the malady, thus eradicating the general pathological condition, eliminating the poisons and disease germs from the system.

To accomplish this object, absolute cleanliness (internal and external), plenty of pure air and sunshine, the religious observance of the laws of hygiene, and a wholesome nutritious diet, are more useful and restorative in their effects than are drugs. All the secretory organs of the body should be required to perform, as nearly as possible, their natural amount of work.

This once accomplished, and all nature's machinery kept lubricated and in good working order, the local treatment and work of reconstruction will be comparatively easy.

The sores, ulcers, acute and chronic, must be kept clean. This is done very satisfactorily by the application of hot water. If the parts cannot be soaked in the hot water, an ordinary fountain syringe can be filled with water (as hot as can be

borne without burning), elevated high enough to give sufficient velocity to the stream which is played over the parts by the operator holding the nozzle of the syringe a short distance from the seat of the application. The frequency of the washing will depend upon the nature of the case, but should be repeated as often as necessary to keep it clean and free from offensive odors.

To destroy pus and bacteria, and to aid nature in the work of rebuilding the parts invaded, I have found hydrozone and glycozone superior to any and all other agents tried.

Hydrozone is first applied (after the hot water) by the use of an ordinary glass dropper, or hard rubber syringe, slowly, all over the ulcer, until the pus is destroyed. Effervescence, or fermentation, continues until the enemy is quite dead, but no longer. One layer of absorbent cotton is saturated with glycozone and placed smoothly over the parts, and held in place by a cotton bandage, sufficiently tight to hold the cotton in place.

Other local medication might do as well in some cases, but I have not so found it. The result obtained in the case I report herewith, seems to confirm the statement as above made.

Edw. K., age twenty-three; American, but German descent; a farmer by occupation; unmarried; rather small in stature, but well-built; having taken sixteen bottles of "blood purifier" and a lot of "anti-constipation pills" within the last eight months for "falling sickness," came to

my office March 19th, with both legs most frightfully ulcerated, from knees to ankles, with considerable discharge of pus from various parts of the legs. Such a case should have been sent to a hospital or sanitarium for the best systematic treatment obtainable, but, unfortunately, he was so situated that he could not be sent to such a place. In a most pleading way he asked me if I could do him any good. I told him I thought so, if he would mind me, and take the treatment that I should advise. He promised, and the treatment was begun.

The legs were cleansed by soaking them for twenty minutes in hot water twice a day, after which hydrozone was used freely all over the sores, to destroy the pus, the pustules having been opened and as much pus evacuated as possible.

After this application, morning and evening, the legs were powdered all over the affected portion with a mixture of equal parts of alum, boric acid and aristol, then covered with absorbent cotton, and bound up with an ordinary cotton gauze bandage.

This local treatment was kept up for two weeks. The improvement was slow, but constant. The process of healing advanced from the knees downward and from the ankle upward, leaving the last part to heal about the middle of the leg, where the ulceration formed a thick crust, extending two-thirds around each leg.

The constant discharge of pus from the sores caused the dressing to stick to the parts, which could not be removed without difficulty.

The alum, boric acid and aristol powder was discontinued and glycozone used as a reconstructive agent, from the end of the second week. The sores were washed and the hydrozone used as before mentioned, then the glycozone was applied to the whole affected parts. A layer of absorbent cotton was saturated with glycozone, and smoothly placed around the sores, and held in place by a cotton bandage.

There was not any further trouble about the bandage adhering to the sore. The granulation was much more rapid than at first. At the end of the next week the results were very gratifying. At the end of the second week after hydrozone and glycozone were used as the sole local agents, the young man said he was well, and worked every day from that time.

The internal treatment was changed from time to time as the case required. Opiates were given several times during the first two weeks of the treatment, to ameliorate the pain, which was very great at times. He was much emaciated and melancholy when he first came to me. His bowels would not move without cathartics.

Fluid extract nux vomica was given morning and noon, seven drops before each meal. Elixir lactopeptin, with bismuth, was given in drachm doses after each meal, and, occasionally, laxatives at night. Later on, tincture chloride of iron was given, in ten drop doses, after each meal, for one week.

After the third week no internal treatment was given, as the patient was in good condition, happy and cheerful.

Hydrozone and glycozone were left to complete the structure, and to place upon it the capstone of a beautiful new integument, which they did in a way gratifying both to the patient and to myself.

Infantile Diarrhœa.

Ewald prescribes:

\mathcal{R}	Benzonaphthol	
	Bismuth, subnit.	
	Resorcin.	ââ gr. iss

M. Sig. : For a child 1 or 2 years old one such powder every two hours until six have been taken.

Dr. Comby sometimes orders

\mathcal{R}	Naphthalin	gr. xv
	Pulv. sacchar.	℥iiss
	Ess. bergam.	gtt. v

Mix and make into 20 packets. From 5 to 10 packets daily, according to the age of the child.

It may be given thus (Baginsky):

\mathcal{R}	Naphthalin	gr. iss
	Calomel.	gr. 1-6
	Pulv. sacchari.	℥v

M. Sig. : For 1 packet. A child 2 or 3 years old may take 5 or 6 packets during the day.

Dr. Filatow relies upon

\mathcal{R}	Naphthalin	gr. ij
	Bismuth. subnit.	gr. 1½

M. Sig. : For 1 packet. One such packet every two or three hours for a child of 2 or 3 years.

—*La Médecine Moderne.*

For Bronchorrhœa.

\mathcal{R}	Copaiba	℥ij
	Tincturæ chloroform composita.	mxv
	Mucilaginis acaciae.	℥vij
	Liquoris potassae.	℥j
	Aquæ cinnamomi	ad ℥vij

Misce et fiat mistura.

An eighth part to be taken three times daily.

—*Western Medical Reporter.*

THE PAY OF PHYSICIANS AND SURGEONS.

The physician is generally sure of a good living, but he must work hard to gain it. The incomes of professional men can be estimated only in an approximate way. Since the amount of money earned is considered by the public as a measure of appreciation of services rendered, there is a strong tendency to give as facts what should be, rather than what actually is. Physicians form no exception to this rule. The average annual income of a physician in full practice in a large city may be stated as \$2,000, and in the smaller towns and in strictly rural districts \$1,200. Two or three physicians in New York make over \$100,000 each year; five or six range from \$50,000 to \$60,000; fifty from \$25,000 to \$30,000; one hundred and fifty from \$10,000 to \$12,000; about three hundred from \$5,000 to \$6,000; fifteen hundred from \$2,000 to \$3,000 and the remainder from \$800 to \$1,000. When we endeavor to estimate the average income of the doctor, we must consider many controlling influences which bear upon his work. When he begins practice, his income will probably range from \$800 to \$1,500 per annum.

Payment for medical services varies in different localities. In the large cities the fees are always comparatively higher. But even in New York the charges are not extravagant. The general family practitioner charges from \$2 to \$5 per visit to the patient's house. The average of such fees for the wealthy is \$5, although twice that sum is usually demanded by practitioners whose practice is mostly limited to that class. Office consultations by experts range from \$10 to \$25, as do also consultation visits. Visits out of town are from \$10 to \$20 for each hour of absence from home, plus traveling expenses, and the regular fee of \$25 for the consultation itself. Surgical operations command the highest prices, and also range according to the skill and fame of the operator, from \$100 up into the thousands. Night calls are twice the amount of day calls, whether ordinary or consultation visits. While all this is true of the established practitioner, the younger men must be content to take one dollar in their offices. In many of the smaller towns the physician gets no more

than half a dollar for an office visit, and but twice that for a call within a mile from his home. Those physicians who confine their practice to a special branch make larger incomes than those who do a general practice. But when we take into account the long preparation necessary, the special studies that must be made and the time spent in attaining proficiency and reputation, the difference in the end is not so great as might at first be supposed.

The pay of the profession in different countries averages about the same when the relative cost of living is taken into account. The fees in Paris for surgical operations run from \$200 to \$5,000. Except that the latter sum is not infrequently paid, there is no difference as compared with American or English rates. Still there are only three or four surgeons in Paris who can command such prices, and only two who are reputed to make \$100,000 a year. The Parisian fee for a surgeon called in consultation is \$20, whether in his office or at the house of the patient. The consulting physician receives somewhat smaller pay, the amount ranging from \$12 to \$20 per visit, while at his office it is from \$4 to \$10. The highest annual income of a French physician is \$40,000, although the late M. Charot is reported to have made much more. The general practitioner in Paris averages \$2 per visit, but in aristocratic circles he demands \$4. Allowance must also be made for smaller living expenses in Paris than in London or New York. In comparing our fees with those of the German physician and surgeon it is well to understand that, although a German mark is reckoned as equivalent to twenty-five cents, its purchasing value in Germany equals our dollar here. Thus the German family doctor, while he nominally gets but 2 marks for an office visit, can really count on \$2 of actual worth to him. The specialists of Berlin and other large German cities charge from 5 to 10 marks for outside calls. The first-class medical authorities, who are necessarily professors in the universities, charge 20 marks in their offices and 30 for house visits. All other things being equal, we can count the average earnings of the German family

doctor to be about 5,000 marks, and the consultant's and professor's income 10,000 marks.

The late physician to the Prince of Wales received for four weeks' attendance at Sandringham, during the illness of his distinguished patient from typhoid fever, not only the usual title of baronet, but a fee of £10,000. Sir Morell Mackenzie is reported to have received more than twice this amount for his treatment of the late Emperor Frederick of Germany. His Royal Highness the Nawab of Rampur, India, recently paid an English army surgeon £50,000 for a three-months occasional attendance in an ordinary attack of rheumatism. This is said to be the largest fee ever paid for medical services in that so-called heathen country. The late Sir Andrew Clark, Gladstone's physician, often charged \$1,000 for running

down from London to Liverpool, and the late Sir William Gull commanded equally high rates for similar services. A Russian surgeon charged a wealthy notable of Odessa \$6,000 for opening an abscess of the hip, the time occupied being about ten minutes. And better still, while on the same visit, he took a chance shot at another patient in the shape of a similarly simple operation, for which he received nearly \$1,500 more. But in all this it is not so much the doing as the knowing how to do. When the French peasant said that there were not ten francs' worth of paint on Rosa Bonheur's "Horse Fair," he was incapable of valuing high art. "Five dollars for amputating the leg," said the surgeon, "and nine hundred and ninety-five for knowing how"—and the victim was thankful accordingly.—*Dr. George F. Shrady, in the Forum for September.*

THE BUBO PLAGUE IN CHINA, WITH A BRIEF ACCOUNT OF THE GREAT PLAGUE OF LONDON.

BURNSIDE FOSTER, M. D.

The first extensive epidemic of the plague, of which history has recorded any definite account, occurred in the sixth century, A. D., and is usually described as the Plague of Justinian, since it existed during nearly the whole of that emperor's reign.

Although there are some discrepancies in the various accounts which I have consulted, the epidemic seems to have had its origin in Lower Egypt in the year 542. From its starting point it traveled up the Nile, and then leaving that stream it swept with increasing fury into the interior of Asia Minor. Constantinople was visited, with the result that for some days the people died at the rate of 10,000 daily. In the next year it traveled over Greece and Italy; in 545 it extended into Gaul and in the following year reached the cities of the Rhine. During the seventy years of its existence this fearful disease visited all the parts of the known world and its victims were numbered by millions. In several instances historians have recorded that more than half of the population of many of the cities, perished, and that scarcely people enough were left

alive to bury or destroy the bodies of those who died.

During the succeeding years of the Middle Ages we have no knowledge of any very extensive plague epidemics until the sixteenth century. In the year 1500 it raged in Germany, Italy and Holland for seven years; in 1534 in southern France; in 1562 for six to eight years it was pretty general throughout Europe. During these epidemics we find it recorded for the first time, that to some extent epidemics were considered preventable, and that there were attempts at disinfection and insolation. Sulphur, arsenic and alcohol were among the earliest disinfectants; and the plague physicians, "Pest Medici" as they were called, wore special gowns and masks and anointed their hands and arms with medicated oil before coming in contact with the sick. During this and the seventeenth centuries a number of severe and fatal epidemics of this dread disease occurred in all parts of Europe, but the one of which I will make special mention is the Great Plague of London which occurred in the year 1665.

De Foe's "History of the Plague," and

the "Works of Dr. Thomas Sydenham," a very eminent physician of that time, give from their different points of view, such a comprehensive and interesting account of the events of that dreadful year that I shall quote from them both in some detail:

In September, 1664, there began to be rumors in London that the plague was again raging among the Dutch and in the latter part of November two men said to be Frenchmen died of the plague in a house at the upper end of Drury Lane. During the next few months there were occasional cases in the same part of the city, but it was not until early in the following May that there began to be any serious apprehension. With the warm weather the cases became more numerous and in the second week in June about one hundred died of the plague in the out parishes and the disease began to appear in the city, and by July 1 the pestilence had become so general that business of all kinds was suspended and many of those who had the means to do so shut their homes and places of business and fled to the country. The panic among the people became so great that many went mad through fear and others deliberately committed suicide to avoid the infection.

De Foe records that the posts of houses and corners of streets were plastered over with doctors's bills and papers of ignorant fellows quacking and tampering in physic and inviting the people to come to them for remedies.

"Infallible, preventive pills against the plague. Never failing preservatives against infection. Sovereign cordials against the corruptions of the air. Anti-pestilential pills. Incomparable drink against the plague. The only true plague water. The Royal Antidote against all kinds of infection, and such a number more that I can not reckon up, and if I could would fill a book of themselves to set them down."

Others assuming specious titles summoned people to their lodgings by such bills as these:

"An eminent High Dutch physician, newly come over from Holland, where he resided during all the time of the great plague last year in Amsterdam and cured multitudes of people that actually had the plague upon them."

"An ancient gentlewoman having practiced with great success in the late plague

in this city, Anno, 1636, gives her advice only to the female sex."

"An Italian gentlewoman, just arrived from Naples, having a choice secret to prevent infection, which she found out by her great experience, and did wonderful cures with it in the late plague there, wherein there died 20,000 in one day."

"There is no doubt," says De Foe, "but these quacking sort of fellows raised great gains out of the miserable people, for we daily found the crowds that ran after them were infinitely greater, and their doors were more thronged than those of Dr. Brooks, Dr. Upton, Dr. Hodges, Dr. Berwick, or any, though the most famous men of their time."

The Lord Mayor and Aldermen adopted very sensible and very stringent measures for the separation of the sick from the well, and for general disinfection, which doubtless had a considerable effect in controlling the disease. An infected house was at once shut up and a watchman appointed to guard it day and night, to see that none entered or left it without special permission. By this means, harsh and cruel as it was in many instances, the infection was to some extent confined and localized. During August the deaths became so numerous that it was impossible to give decent burial to the bodies. Great ditches were dug, and the bodies, without discrimination were cast into them. It was estimated that above ten thousand houses in London were deserted and that about two hundred thousand people left the city. From August 8 to October 10, according to the mortality bill there died in London 59,810 people, of whom 49,605 died of the plague. The total number of deaths from the plague during the epidemic is placed by De Foe at 100,000. From November 1 the number of cases began to diminish, the death rate of those attacked became smaller and as winter came on, people returned to London, resumed their business and by February of the next year the great plague was over.

In regard to the nature of the infection by which the disease is spread, De Foe, after discussing various opinions says: "Others who talk of infection being carried through the air only, by carrying with it vast numbers of insects and *invisible creatures*, who enter into the body with the breadth or even at the pores with the air, and there generate, or emit acute

poisons, or poisonous ovæ which mingle themselves with the blood and so infect the body." Strange that the actual discovery of germs and of the ptomaine theory should have been delayed for two centuries!

The symptoms of the disease are thus described by Sydenham:

"Its first approach is almost always accompanied with shaking and shivering like the fits of an ague; presently violent vomiting, a pain about the region of the heart, a burning fever with the usual concurrence of symptoms perpetually afflict the sick till either death itself or a happy eruption of a bubo discharges the morbid matter and so frees them from that deplorable condition. It does now and then happen that it comes without any sense of fever before and suddenly kills men; the purple spots which are the forerunners of death breaking out as they are about their business. But this sudden death scarce ever happens but at the beginning of a dreadful plague. It sometimes also happens that swellings appear when neither a fever nor any violent symptoms went before. The victims sometimes died within a few hours of the first symptoms, and rarely lingered beyond four or five days. If the buboes suppurated it was considered to be a favorable circumstance and they were therefore treated by incision or by caustic."

The other local manifestations were carbuncles, furuncles and ecchymoses. A peculiar and characteristic stench was omitted from the bodies of the sick. At the beginning of the London Plague upwards of 90 per cent. of those attacked, perished. Towards the end of the year the disease seemed to have become milder and the mortality was much less.

I have gathered from various sources a pretty accurate description of the epidemic now devastating China, and its identity with the above is undoubted.

The disease first appeared in the Province of Kwantung in the latter part of March and spread principally among the poor and filthy, with frightful rapidity. More than half a million people perished in two months and the great commercial centers, Canton and Hong Kong, were soon attacked. In the former with a population of 1,000,000, the number of deaths exceeded 100,000!

The symptoms are thus described: With or without premonitory warning in the shape of malaria or chill there is a sudden onset of fever, rising to 105° F. or over;

there is much headache and cerebral disturbance accompanied by stupor. In from twelve to twenty-four hours glandular swellings occur in the neck, armpits or groin, rapidly enlarging to the size of a hen's egg; these are hard and exceedingly tender; with or without a decline of the fever the patient sinks into a deeper condition of coma and dies usually at the end of forty-eight hours or sooner. If six days are reached recovery is hopeful. The glandular swelling shows no signs of suppuration, in some cases epistaxis or vomiting of blood occurs. Petechiæ appear in a few, but there is no regular eruption. The mortality is about 90 per cent.

In the latter stage of the disease, when the local manifestations are most apparent, the fever usually diminishes and there occurs a sticky and very offensive perspiration. The inguinal and femoral glands are those most commonly affected, although those in the axilla and neck are often involved at the same time. The carbuncles are of less constant occurrence than the buboes and are usually seen on the lower extremities, the buttocks and the back of the neck. Among the sequelæ in those who finally recover, are continuous suppuration of the buboes, abscesses of the skin and muscles, pneumonia, dropsy, partial paralysis and mental disturbances.

The malady is undoubtedly a filth disease and caused by a bacillus. Indeed, Professor Kitasato, a competent bacteriologist and a pupil of Koch, claims to have discovered the specific germ. There is no doubt and it has been repeatedly demonstrated during the last one hundred years that efficient quarantine gives absolute protection from the disease, and that modern sanitary means can rapidly stamp out an epidemic should a few cases be imported into a well ordered community. It has been well named, "the disease of barbarism," from the fact that it only occurs among the semi-civilized. There is little to be said concerning treatment. There is no known specific and the treatment, like that of all acute fevers, must be supporting and symptomatic. Should there be given sufficient opportunity to study this disease scientifically, which is not at all likely, I am convinced that the only specific medication would be found in the development of the antitoxin theory. It is also probable that immunity might be given by inoculation of an attenuated virus.—*Jour. Amer. Med. Ass'n.*

SOCIETY REPORTS.

LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

May 4, 1894.

[STENOGRAPHICALLY REPORTED BY C. C. MAPES.]

ABDOMINAL TUMOR—CONTINUED REPORT.

DR. A. M. CARTLEDGE: This gentleman, Mr. H., was before the society one month ago for examination because of an abdominal tumor. The consensus of opinion at that time was that the spleen constituted the tumor. Some days afterward I did an exploratory section and the trouble was found to be the liver which is displaced, with a number of adhesions around it, showing evidences of several attacks of circumscribed peritonitis. The adhesions were carefully separated, but the liver was, of course, not raised to its normal position. In the light of second knowledge, it is very easy to demonstrate the situation of Mr. H's liver; he has no liver in the normal site. It has not been quite four weeks since the operation, and his recovery from it has been uneventful.

I believe there has been great relief. He says he feels much better; the liver has decreased very much in size, being now almost normal except its situation; his complexion has also improved very much.

DISCUSSION.

DR. T. S. BULLOCK: I saw Dr. Cartledge perform the exploratory laparotomy on this man; in fact, I was the anæsthetist, and he called my attention to the situation of the tumor, and its appearance. It could be demonstrated at first glance that there was absence of the liver in its normal situation, and its presence in this abnormal position—a dislocation of the liver.

DR. A. M. CARTLEDGE: Mr. H. has been examined repeatedly by some of the brightest and most eminent doctors, as he says, in several States, and no one even suggested that the trouble might be the liver. It has been diagnosed various things, but the correct diagnosis was never made until after the exploratory incision.

DR. J. W. IRWIN: I recollect that I examined this gentleman when he was presented by Dr. Cartledge before the society on a former occasion. I am very glad that the doctor brought the case before us again to-night and corrected a very greivous error. It seems reasonable that any man should be able to tell by percussion whether there was dullness in the region of the liver or spleen, but this case seems to be one that has misled—so to speak—a great many. At the previous examination his abdomen was more tympanitic than it is to-night; there was not any very marked dullness over the region of the spleen, in fact hardly any, and there was perhaps not quite so much over the region of the liver; yet there was some defined dullness. However, the case was hardly one that would be considered in a perfect state for examination, the abdomen was very tympanitic at that time, neither was his position from necessity such as we would like to have. But this illustrates a very important thing—how ready we are to give opinions without making a thorough and careful investigation of the case. I believe I am among those who stated at the previous examination that there was practically no dullness over the region of the spleen, and can only account for it as I have stated.

DR. TURNER ANDERSON: It is the most remarkable case that I have ever seen presented to a medical society. I have never before seen a case where the liver was in the left iliac fossa.

DR. A. M. VANCE: I examined this man when he was before the society on a former occasion, but did not make any diagnosis. The case illustrates the fact that we ought to be very careful and go slow in making our diagnoses in such cases.

DR. T. S. BULLOCK: I was present when several of the members percussed

this patient's liver, and although Dr. Cartledge stated when he presented the case that there was a suspicion that it was a displaced liver, he was not certain until he made the exploratory incision. I listened while Dr. Marvin and several others percussed the region of the liver at the first examination, and thought I detected the normal dullness of the liver, and was very much surprised to find when exploratory incision was made, complete absence of the organ in the normal situation. Dr. Cartledge at the operation demonstrated to his own, and to the satisfaction of every gentleman present, the absence of the liver in its normal site; he demonstrated the lobes of the liver and the gall bladder in the abnormal position, and there can be no question about its being a displaced organ.

PARALYSIS FACIALIS.

DR. W. O. ROBERTS: Two weeks ago this young man while driving in a dog cart, his horse fell and he was thrown out striking his head on the pavement. He was unconscious for fifteen minutes. After regaining consciousness he was taken home in a carriage, and had considerable hemorrhage from the ear. Then hemorrhage kept up, not continuously, but at intervals, for forty-eight hours; there was not succeeding the hemorrhage any watery discharge from the ear. Tuesday following the accident facial paralysis was first noticed. I had him come here to-night because I thought it was a case that would be of interest to the specialist. He evidently has either a fracture through the temporal bone involving the canal through which the nerve passes, or a clot, or inflammatory product. The accident occurred in Friday and facial paralysis developed the following Tuesday. All that was done in the way of treatment was during the time the hemorrhage was going on, the ear was thoroughly irrigated with hot water with a view of stopping the blood. Since then it has been frequently irrigated, because, while there was little or no discharge from the ear, it was quite offensive. Dr. Ray has examined the case and can tell us the condition in which he found the canal.

DISCUSSION.

DR. J. M. RAY: Dr. Roberts kindly asked me to see this patient on Wednes-

day following the accident. I examined first his ear by the speculum; found the roof of the canal had been pushed down. The surface of the drum membrane was covered with blood which had become dry. There was no discharge from the ear. As far as his hearing powers were concerned, air conduction was destroyed but he could hear the turning fork by bone; this I think demonstrates the fact that the internal or nervous portion of the ear is not involved. Therefore there is a fracture probably extending through the roof of the canal and through the membrana tympani into the roof of the middle ear, involving the Fallopian canal. The question of course comes up as to whether the paralysis is due to fracture and pressure by a spicula of bone upon the nerve, or whether it is due to hemorrhage. The prognosis to a certain extent also depends upon that. I have seen several cases of this kind which recovered very promptly. Fractures through the temporal bone are, I think, quite common in head injuries. Dr. Vance will recall a case that we saw some time ago. I reported the case at the time and looked up statistics on the subject and found there was quite a variety of opinion, some authorities claiming that the fracture did not involve the roof of the middle ear unless there was escape of the cerebro-spinal fluid, others claiming that frequently there is no escape of fluid. Buck reports cases where there was no escape of fluid and very little hemorrhage. Fractures through the middle ear cavity and even fractures about the base, are quite frequently overlooked. I have seen several cases of head injuries where there was paralysis of different muscles; Dr. Vance will remember the case of a child I saw with him where there was paralysis of the sixth nerve from head injury, and at the same time enormous retinal hemorrhages. The child recovered very promptly.

DR. S. G. DABNEY: It would seem to me that from the paralysis coming on three or four days after the injury, the case should be regarded as more hopeful. If there was a fracture and pressure of a spicula of bone on the nerve, we would naturally expect paralysis to have taken place immediately. Ruptures of the drum membrane from falls or blows on the ear are not rare. This spring I saw one produced by a snow

ball hitting the ear. I have seen several cases similar to the one shown to-night, but without the facial paralysis; I do not remember to have seen one having that feature. I remember one case resulting from a child sliding down the bannisters, falling at the bottom and striking the head. There was unconsciousness for sometime and later there was quite a free discharge of blood, without any watery discharge from the ear. There was a rupture of the drum membrane with some disturbance of gait, and later some disturbance of sight of the same side. Taking into consideration the disturbance of sight led me to make an ophthalmoscopic examination in that case, and I found the retinal veins of the corresponding eye considerably engorged. All the symptoms disappeared in a few weeks, the drum membrane healed, and the hearing was good though never quite perfect.

DR. WM. CHEATHAM: It seems to me that what Dr. Dabney says about the case shown by Dr. Roberts is about correct. The paralysis coming on so late leads me to believe that it is most likely from swelling and not from pressure of a spicula of bone. My experience has been in these cases of paralysis that they get well but that they are a long time doing so. I have seen them as long as three years making a satisfactory recovery, especially where the eye muscles have been involved. In a great many cases there is some general disease of the nervous system, which should be taken into consideration in making a prognosis.

DR. TURNER ANDERSON: I associate this case with Bell's paralysis, the result of trauma very similar to the conditions that we observe in forceps application where the momentary depression of the mastoid process is such as to permit undue pressure upon the nerve as it passes through the canal.

DR. J. W. IRWIN: Two or three years ago I saw a boy sixteen years old who had been struck by a sixteen pound iron ball on the frontal os; he was knocked senseless. I saw the patient five hours after receipt of the injury and he had some bleeding from the ear, followed by a straw colored discharge—serum. There was no paralysis attending the injury. I think very likely in Dr. Roberts' case the diagnosis is correct, and I believe the trouble is due to inflammatory effusion. Whether

there is a fraction or not, no one can tell.

DR. H. A. COTTELL: About the only question arising in the case is the location of the hemorrhage; the probabilities are that the trouble is due to pressure upon the facial nerve the result of inflammatory action as Dr. Anderson suggests. It is possible, however, that the condition is purely hemorrhagic. You can indulge in almost any number of theories as to the cause, but one thing is certain, there is pressure upon the nerve in the Fallopian canal. I should say the prognosis is favorable in such a case; about as favorable as it usually is in Bell's palsy. It is well-known that Bell's palsy is originally a traumatic palsy. The way the disease came to be called "Bell's palsy" was by virtue of the fact that Sir Charles Bell attempted to relieve a very severe facial neuralgia (before the function of the fifth and seventh nerves were discovered) by incising the seventh nerve. This produced complete paralysis. Bell's palsy was therefore originally a traumatic palsy. We know that in ninety-nine cases out of a hundred of Bell's palsy, (paralysis of the facial muscles) the trouble is in the Fallopian canal; the facial nerve in going from the internal auditory meatus to the stylo-mastoid foramen traverses a certain part of the petrous portion of the temporal bone, and any trouble—be it congestive, traumatic, inflammatory or whatever it may be—causing pressure upon the nerve in that region will produce what we call facial paralysis. If all the muscles are involved, we know that the trouble is peripheral; if there is involvement of only a few of the muscles, we know the trouble is central. The majority of cases completely recover. In the case before us I should incline to make a favorable prognosis, but I believe electro-therapy is indicated in the case.

Dr. W. O. Roberts presented a report of
LAPAROTOMY FOR RELIEF OF INTUSSUS-
CEPTION; WITH REPORT OF A CASE
OCCURRING IN A CHILD
AET. NINE MONTHS.

(See page 428.)

DISCUSSION.

DR. TURNER ANDERSON: Dr. Roberts has reported the case so fully that there is really nothing left to be said. I saw the

patient one and one-half hours before the operation. The child when first seen presented the unmistakable physiognomy of a serious illness, that was simply all. It was being carried around the room upon its mother's arm and would occasionally manifest evidence of abdominal pain, but was not screaming; except for the pinched appearance of the countenance, I would scarcely have recognized that the child was more seriously ill than when suffering from an ordinary attack of colic. But the history of the case was important; the child had been ill four days under the care of a very excellent medical practitioner. He had suggested the day before that an operation be performed, and I am satisfied had made (although I do not know positively) a diagnosis of the condition. Diagnosis of the case was not difficult; the abdomen was not especially distended, in fact there was very little tympanites, but there was a sausage roll extending from the region of the sigmoid flexure upwards for about four or five inches, and at variable intervals the child would manifest considerable discomfort and straining. Upon inspecting the rectum there was no difficulty in detecting the protruding mass just within the sphincter, which, as Dr. Roberts has said, came out after the child was partly under the influence of the anæsthetic, possibly two inches through the sphincter muscle. I had the child suspended by the legs and introducing my finger into the rectum I could press up the invaginated portion, and at first I pressed it so far that I hoped it had been returned. I could feel all the way around it, could dilate the gut to such extent as to make the diagnosis complete. It began at the cæcum, passing through the colon, carrying with it the vermiform appendix and pulling down the smaller bowel as it descended through the large bowel and rectum to the anus, so that when it was relieved the last portion to come out was the cæcum and the appendix. The cæcum and appendix were so enlarged and œdematous that had they been seen at first there would have been a suspicion that the trouble was malignant in character. In other words, the morbid processes had extended to such an extent as to at first sight make the condition questionable.

With reference to the symptoms in these cases: I think the most important are

straining, bloody dejections and the absence of natural alvine evacuations. Ordinarily a tumor can be detected, such, at least, is my experience.

DR. A. M. CARLEDGE: The only case of obstruction of the bowels that I have seen in the young child occurred in a little girl three years of age and was volvulus. The only case of invagination I have seen in a surgical way in the adult occurred in a young man in Indiana about a year ago. I exhibited the specimen and reported the case at some length before this society at the time. The invagination was at the ileo-cæcal valve and was about eight inches in extent. I resected the invaginated mass and made an end to end anastomosis, but necrosis and gangrene had taken place at the time of the operation and the patient died three hours afterward.

DR. A. M. VANCE: I have never performed a laparotomy for intussusception, although I have seen several cases in which operation has been advised by others. I was recently called to see a child five months old reported to be suffering from invagination; I did not think operation advisable in the condition in which I found the child. The child died the day following. It is a wonder to me that invagination does not occur oftener, when we consider the tremendous suction power of the intestine. I have demonstrated this a great many times in operating upon dogs in endeavoring to make an end to end anastomosis. In approximating the afferent and efferent ends, the afferent would sometimes be sucked into the lower and requiring considerable force to bring it back by the suture attached. I can understand readily how when invagination starts it would be carried right along by the sucking power of the intestine, the bowel above contracting and the muscular coat relaxing below forcing the intussusceptum downward very rapidly. In making an end to end anastomosis upon dogs I have often inserted my finger into the end of the lower portion of the intestine and the suction and contraction is so great as to make it perceptibly painful.

My experience is that babies particularly stand abdominal surgery very badly. I think the percentage of deaths would be more than double as compared with people who are older.

DR. C. SKINNER: I do not think all cases of appendicitis should be condemned

to the knife, but do believe that all cases of intussusception belong to the surgeon.

DR. H. A. COTTELL: As I stated before a recent meeting of this society, in discussing the question of appendicitis, the only case of intestinal obstruction, which was probably appendicitis never made out, that I had seen which proved fatal occurred in the person of a child two years of age. We had the counsel of several eminent physicians and at least one eminent surgeon. The case was decided non-operable, the opinion being based upon the extremely tender age of the patient. I am satisfied, however, that a case in the hands of Prof. Anderson or Prof. Roberts would get all the chances of life that science could give it. I doubt if operation on any patient of such a tender age could be done with any reasonable hope of success.

DR. J. A. LARRABEE: It has been my fortune—or misfortune, I take it—to have seen quite a large number of cases of intussusception. In looking back over my practice I can recall by name thirteen cases, 12 deaths and one attempt at recovery. One of them came very near being a repetition of the very strange case referred to by Dr. Roberts to-night. A negro child that lived three weeks after sloughing of the intestine, then died of perforation.

One point mentioned by Dr. Anderson in regard to these cases has been borne out by my experience, i. e., the diagnosis is not as difficult as it might at first present. It is a little strange that earlier diagnosis is not arrived at when we take into consideration the facts already recited to-night. The history of these cases is that they are always of sudden occurrence; next, the peculiar facial expression—Dr. Anderson has alluded to that, and I consider it one of the best points made in connection with the subject—there is not as much pain as is manifest in ordinary colic, but there is never a case without that peculiarity of expression which he has so correctly described. Again, I have never seen a case in which I was not able to make out a sausage-like tumor, except one. This occurred in a child suffering with an attack of varicella; intussusception came on without any cause, and like most such cases occurred suddenly at, or immediately after, straining at stool.

Dr. Vance has brought up a very sig-

nificant fact in this connection, viz.: the suction of the intestine; when the intussusceptum once gets started it is carried on by this suction. Most of the cases I have seen have occurred immediately after efforts at stool. As I have already stated the diagnosis in my experience has been comparatively easy; I have never made more than two visits before satisfying myself as to the diagnosis. As Dr. Skinner has very correctly said, these cases are strictly surgical just as soon as they are diagnosed, and with the power of making early diagnosis, with the facts against its being anything else, either in the very young or the very old, I think the surgeon ought to be employed very early. I am a little surprised to hear Dr. Vance say that babies stand abdominal surgery so badly; I did not know that the operation was attended with such fatal results. I think the hope we have for relief by means of surgery is greater than by medical treatment; in my experience five days was the limit of life in these cases treated medically.

DR. W. L. RODMAN: I think the relative frequency of intussusception in children is clearly due mostly to anatomical reasons; due to the same cause which makes hernia so very common in young children. In early childhood the mesentery is nearly twice as long relatively as it is in the adult; this same mesentery becomes again elongated in older subjects. This to my mind explains the comparative frequency of intussusception and hernia in the young, and in advanced age.

I fully agree with the position taken by Dr. Roberts as to the treatment. I feel that the importance of surgery in these cases cannot be over-estimated. While enemata may relieve a few cases in the very early stage of the trouble, and I think it should be always tried, just as taxis should always be tried in early strangulated hernia, I am satisfied that it should be tried no longer than taxis in hernia, and should the enemata fail to relieve the case very promptly I am thoroughly satisfied that the case demands early laparotomy. I therefore agree with the essayist that most of these cases call for a laparotomy, though they should certainly be treated medically at first. I hardly believe that the morality is as great as statistics would make it appear. If the cases could be seen and operated on as

early for instance as in strangulated hernia, I think the results would be very much better than they now seem to be. Certainly nature will do less for these cases than obtains in strangulated hernia, therefore early laparotomy for relief of the intussusception is demanded, and when the operation is done early in the attack I believe results will be more favorable.

TUMOR OF THE MAMMARY GLAND—OPERATION.

DR. W. L. RODMAN: This specimen is the left mammary gland removed from a young woman, married, twenty-seven years of age, kindly referred to by Dr. Goslee of Carrollton, Ky. She gave the history of having borne one child aged three years, which was nursed for eighteen months. Shortly before Christmas last she noticed a small hard lump about two inches above the left nipple. It was painful from the first, but grew more so gradually. Her general health I may say was not good, and an examination of her urine showed quite a perceptible amount of albumen. This made me hesitate as to whether or not I should remove the tumor, but, on account of the fact that it was causing her considerable pain, and the mental distress was very great on account of the presence of the growth, I thought it wise to remove the gland. I did so one week ago last Wednesday, removing the entire organ, as I believe that to be the only treatment for any form of neoplasm of the breast whether benign or malignant. I may say that I thought before the operation that this tumor was probably benign, notwithstanding the fact that she had complained, of considerable pain. It has not yet been microscopically examined, but this will be done in the course of the next few days and I will make a further report. I take it to be a fibroma. Fibromas of the mammary gland are sometimes attended with pain, just as they are in other situations. The axilla was not invaded as I thought the growth was begin. The mammary gland was removed in its entirety an elliptical incision eleven or twelve inches long being made. In changing the dressings yesterday I found that the wound from end to end had healed completely without a single drop of pus. I gave chloroform and administered a very small quantity of it, removing the

breast very rapidly so as to not damage the kidneys more than they already were.

DISCUSSION.

DR. H. A. COTTELL: Cases of neoplasm of the breast are always interesting to me, because of the fact that the first case I ever saw, which occurred fifteen years ago in the practice of Dr. E. R. Palmer, in the person of a darky girl, both breasts enormously enlarged. Under treatment non-surgical those breasts were soon reduced to the normal condition. I remember the case very distinctly, and know the darky to-day and she has raised quite a family of children. The condition was always a mystery to me. The mammary glands are normal to-day. Of course we may have any sort of neoplasm of the breast—sarcoma, carcinoma, epithelioma, endothelioma, etc., and we may have fibroma, adenoma or simply an inflammatory condition which we may call hyperplasia. A great many cases of mammary tumor which are condemned to the surgeon's knife I am satisfied are simply the result of an inflammatory action following an abscess.

The worst case of neoplasm of the breast that I ever saw, which progressed most rapidly, which proved to be malignant, returning after operation to destroy the woman's life, was under the microscope purely an adenoma; under the most careful examination it was impossible to make out any species of cancer.

While we are on the subject of carcinoma, etc., I recall some statements I made seventeen years ago which will bear a repetition: When you come to the question of cancer, you are never sure that the tumor you are dealing with is malignant or non-malignant in character until you can demonstrate infiltration into the surrounding structures. For instance you take a pure epithelioma beginning in the rectum, or cancer of the bowel, and it is to all intents and purposes a normal structure until it has broken loose and begins to infiltrate into the surrounding structures. It is a common thing in demonstrating pure epithelioma, to show students a normal section of the rectum, then afterward show them what is called cylindrical epithelioma, and no distinction can be made until the muscular coat of the bowel, the peritoneum or surrounding organs have been invaded by the disease.

DR. W. L. RODMAN: How many specimens of pure adenoma of the breast have you examined microscopically?

DR. H. A. COTTELL: I do not recall of course the exact number, but perhaps a dozen.

DR. W. L. RODMAN: Gross in his book on tumors of the mammary gland, says that he never saw but one case of pure adenoma of the mammary gland—fibro adenomas are more common. Bryant called them adenocoeles.

DR. H. A. COTTELL: If you insist upon *pure adenoma*, it may make some little difference, of course I referred to the cases usually denominated adenoma, and it is a fact that a great many of these cases do occur.

I have a case that I would like to report which as far as my experience is concerned, is rather unique. A boy aged six years was brought to my office to-day, who in climbing a ladder carrying a bag in a difficult position discovered when he came down from the ladder that he was weak and out of fix. This happened a week ago. He went into the house and told his mother that something had happened to him, that he had hurt himself in some way. She told him to go up stairs and go to bed, that she thought he would be all right shortly. He found it very difficult to get upstairs. In a few hours he came down crawling on his hands and knees. The condition of the boy is peculiar; he has complete paralysis of the left leg, involving the muscles of the hip, muscles of the back below a certain line, below the dorsal region, incontinence of urine; everything below that totally paralyzed. I suppose we would call it *quarto-plegia*—it is not hemi-plegia, and not para-plegia. The right limb is in perfect condition. By the use of electricity the reaction of degeneration is not marked. I report the case because I want some light thrown upon it if possible. I am of the opinion that it is a case of spinal hemorrhage; it is certainly peculiar that it should have so affected the spinal cord. The boy's temperature and pulse are normal. There are no symptoms of any kind except complete loss of both motion and sensation in the left leg, and incontinence of urine. The patient was referred to me by a physician in the country. I suggested that the case be put upon iodide of potassium and ergot for two weeks, with instructions that the re-

sult be reported to me at that time. I take it to be a case of limited spinal hemorrhage. We all know very well that certain violent straining exercise, certain things which twist the spinal cord may produce hemorrhage.

Caustics in Malignant Growths.

Of late the tendency seems to be to use caustics in treating certain malignant growths, especially those of the skin and superficial parts. Dr. John Parmenter, in the *Journal of the American Medical Association*, advocates the use of caustics on the ground that recurrence of the growth is less frequent, that caustics have a selective action and that they reduce enlarged lymphatics near the seat of disease. We must use the proper caustic and use it intelligently. Of the various escharotics the author prefers Bougard's or Vienna paste, the composition of which is as follows:

Wheat flour.....	60 grams
Starch.....	60 "
Arsenic.....	1 "
Cinnabar.....	5 "
Sal ammonia.....	5 "
Corrosive sublimate.....	0.50 centigrams
Sol. chloride zinc at 52.....	245 grams

From his work Dr. Parmenter concludes as follows:

1. The value of caustics in the treatment of malignant disease depends upon the use of proper caustics and their intelligent application in suitable cases.
2. A proper caustic is one which completely destroys and removes the malignant tissue.
3. Mild caustics are inefficient and dangerous, and therefore to be avoided.
4. Bougard's paste is the most generally useful escharotic.
5. Proper technique in application accentuates the value of caustics.
6. The suitable cases are those which have a limited extent and are easily accessible, or in other words, cancer of the skin, lip and external ear, in their incipient stages.
7. The prognosis should be most excellent, cure resulting in the vast majority of cases when treatment is early and thorough.

Small-Pox.

Salicylate of soda.....	ss	3ij
Antipyrin.....	ss	3iv
Aq. menth. pip.....	ss	3iv
Glycerin.....	ss	3iv

M. Sig.: Tablespoonful three times a day.

—Med. Review.

THE LIBRARY TABLE.

BOOK REVIEWS.

An International System of Electro-Therapeutics: For Students, General Practitioners and Specialists. By Horatio R. Bigelow, M. D.; and Thirty-eight Associate Editors. Thoroughly illustrated. In one large Royal Octavo volume, 1160 pages, extra cloth, \$6.00 net; sheep, \$7.00 net; half-Russia, \$7.50 net. Philadelphia: The F. A. Davis Co., publishers, 1914 and 1916 Cherry street.

This work contains the articles of 38 different writers and represents four countries, United States, Canada, Great Britain and France, the great bulk of the writers being American. It is a notable fact that no German author appears in its pages as a contributor.

The whole field of medicine is considered with reference to electricity as a therapeutic agent, and the book is thus divided into sections, A. B. C., etc., the first being occupied with electro-physics and medical apparatus, the second with electro-physiology, etc. Each set of organs of the human body is the subject of electric treatment from the medical as well as oft-times from the surgical standpoint. With the exception of the first, the largest section of the book is the one devoted to gynecology. It contains 234 pages and gives the electrical treatment for all the diseases of the female pelvic organs from pus tubes and extra-uterine pregnancy to disorders of menstruation. It is in this field that the electrician has engaged in bitterest conflict with the surgeon. The former does admit that there are indications for the use of the knife, but it is not likely that he will be able to persuade the general practitioner to go to the same lengths as himself in the so-called conservative treatment of diseased appendages.

In a work of this character there is of necessity considerable repetition throughout the book; and from the standpoint of a reference book, this is rather an advantage than a disadvantage, for the reader can find what he wants by consulting a single article instead of reading the book as a whole.

The book does not contain new ideas, and it is probable some of the methods there advocated are already antiquated, as must be the case in every advancing science.

It is a matter for congratulation that our knowledge of electricity in a medical sense has been collected and systematically arranged as in this work.

It will no doubt remain for years the standard book for reference on this subject, and should be in the hands of every physician interested in this branch of medicine.

The book itself is well illustrated and neatly gotten up, and does credit to the well-known firm who published it.

A Clinical Manual. By Andrew MacFarlane, A. B., M. D.

This little work contains the directions for making an examination of the urine, feces,

blood, stomach contents, and some exudates and pathological fluids, and is intended as a hand-book for physicians and students examining these substances to complete a clinical diagnosis.

A Primer of Psychology and Mental Disease. By C. B. Burr, M. D., Medical Superintendent of the Eastern Michigan Asylum, etc.

In his dedication the author states that his intention was to simplify an abstruse subject, and he seems to have kept this object in view throughout the work; so that it is doubtful if any other book on this subject gives a beginner more practical information in as small space.

Essentials of Diseases of the Eye, Nose and Throat.

This is one of Saunders' series of Question Compends and is the second edition of this number.

The work is divided into two sections—Essentials of Refraction and Diseases of the Eye, by Edward Jackson, A. M., M. D.; and Essentials of Diseases of the Nose and Throat, by E. B. Gleason, S. B., M. D.; and will be found useful to students preparing for examination or for a course in a dispensary where these specialties are treated.

Essentials of Nervous Diseases and Insanity. By John C. Shaw, M. D.

This work is one of Saunders' series of Question Compends, and the second edition which has just appeared, differs from the first mainly in the correction of a few errors. While dealing with the subjects treated as fully as a book of this size could, it is intended as a preparation for the study of one of the larger text books, and as a resume for advanced students preparing for examination. List price \$1.00; 48 illustrations and cuts in the text.

Human Physiology. By John Thornton, M. A. Crown 8 vo. 268 illustrations and cuts in the text. Longmans, Green & Co.

This book goes as fully into the subject as teachers in public schools, academies, etc., usually care to, the subject of reproduction and the organs concerned is carefully avoided, and the book being written in a rather easy, interesting style should find favor in the smaller schools, etc.

Essentials of Pharmacy. By Lucius E. Sayre,

is the title of another of Saunders' Question Compends, now in its second edition. It is intended especially for students of pharmacy, follows the pharmacopoeia closely, and the new edition is brought strictly up to date to correspond to the pharmacopoeia of 1890.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

VIRGINIA MEDICAL MONTHLY
for September. Dr. Bedford Brown advocates
The Cold Poultice

as a means of reducing pyrexia, when the cold bath or cold pack is undesirable or inconvenient to apply. Boiling water is slowly mixed with constant stirring, with enough flaxseed meal to make a layer a quarter of an inch or less in thickness and about eighteen by twelve or fourteen inches. This is spread uniformly over cotton cloth, covered by another layer and sprinkled with ice water until the temperature falls to 70° or 75° F. It is then applied over the abdomen and chest.

If desired a narrower poultice may be applied over the spine. The author says this acts as a prompt tonic to pulse and nervous system generally, and will reduce a high temperature almost as much as the coal tar antipyretics, and without their depressing effects.

Dr. A. R. Shands gives the result of his experience with the

Treatment of Clubfoot by Wolff's Method.

The method described is the application of rubber adhesive plaster to hold the foot in the best position obtainable at the first dressing. The malleoli and any other bony prominences are now protected by strips of cotton cloth—the whole leg up to the tuberosity of the tibia covered by a double layer of canton flannel bandage, and, finally a couple of plaster of Paris bandages are applied—the limb all this time being kept as much corrected as possible.

Next day over the prominence of greatest deformity a wedge-shaped piece of plaster is removed, two angles being connected by a linear incision around the rest of the plaster casing. The foot is now forced into a position of greater correction and another plaster roller applied (over the first) to keep it so. These incisions are most easily made with a small, fine, handsaw; the blade of which must be dipped in water frequently.

Severe excoriations are apt to result if care be not taken to exclude any fold of skin from slipping between the edges of the cut plaster bandage.

After redressing two or three times, a new dressing must be applied, and the process continued. Finally a position of over correction must be obtained, a small strip of steel incorporated in the final plaster roller, a leather boot applied over all and the apparatus worn for some months.

The author has been well satisfied with his results.

Other papers in this issue are: "Some Remarks on Epilepsy, and the Care of Epileptics on the Colony Plan," by Dr. William F. Drewery; "The Antiseptic Treatment of Infectious Diseases and their Poisonous Remedies Rendered Innocuous," by Oswald L. Schreiner, Ph. L.; "Tuberculosis in Ani-

mals," by E. P. Niles, D. V. M.; "Difficulty Yet Importance of Recognizing Chancre of the Os Uteri," by Dr. H. R. Coston; "Notes on the Treatment of Diphtheria and Croup," by Dr. R. B. James; "The Prevention of Blindness," by Dr. Benjamin Lee; "Elephantiasis Arabum Cruris," by Dr. Larkin W. Glazebrook.

JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES

Drs. J. Abbott Cantrell and Emanuel J. Stout, after quoting several authorities who state that favus may appear on parts of the body free from hair, the palms of the hands, glans penis, soles of the feet, etc., describe a case where large parts of the body were covered by lesions of this disease.

The patient was an Italian immigrant, ten years of age, five feet in height, weighing about one hundred pounds, fairly well nourished.

The whole hairy scalp was affected, the back and sides of the body, outer surface of both arms, left buttock, were affected and smaller lesions on the legs. The mouse like odor was quite noticeable, and a venereal patient on the same floor contracted the disease while this patient was in the house, although proof of direct contagion was not found.

Microscopic examination of a crust confirmed the diagnosis.

Cases reported by other authors are quoted, and the paper will be continued.

Dr. Samuel Sherwell reports a case (still living) of

Ichthyosis Congenita.

A female infant first seen when about one month old. The child was born of American parents, the father of German descent, and has a negative family history. The estimated weight at birth was two pounds, and at that time there appeared to be abnormal coating about one-quarter of an inch in thickness over the body. For about one month the only treatment was free lubrication with olive oil, and a certain amount of improvement has taken place. At first olive oil alone was used; then soft vaseline was added to this, and by gentle friction the outer casing was partially removed.

Baths containing a little borax are used, followed by inunctions, sometimes with cold cream, sometimes mutton fat, etc. The neglect of these for a single day shows very quickly in an increase of the collection on the skin.

The infant is now scarcely seven and one-half pounds in weight.

Dr. Burnside Foster proposes a

New Method of Treating Acute Gonorrhoea.

The author has not yet tried this method, but thinks an early perineal incision, with drainage of the bladder by a tube and anti-

septic irrigation of the urethra from behind offers a speedy cure with sequelæ.

Although thinking the adoption of this method would elevate the standard of morals, it is proposed rather as an ideal treatment than as one likely to be eagerly accepted.

Dr. W. H. Brinley makes a

Plea for Rectal Examination in the Diagnosis of Obscure Disease of the Sexual System.

The author thinks hemorrhoids, even when quite small, rectal ulcers, fissures, fistulæ, and papillomatæ the unsuspected cause of numerous obscure sexual disorders. The removal of hemorrhoids by any other method than excision he thinks crude and out of keeping with modern surgery.

Dr. M. B. Hartzell contributes an article, illustrated with micro photographs, on "The Protozoalike Bodies of Herpes Zoster."

JOURNAL OF NERVOUS AND MENTAL DISEASES

for September. Dr. W. H. Riley contributes

A Study of the Temperature Sense.

In his investigations the author divided the surface of the body into fifteen areas, and came to the following conclusions. "The parts of the body given in the order of their sensibility are as follows :

1. Abdomen, sacral and lumbar regions of the spine, with the intervening space on each side of the body.
2. Inside of the thigh, chest, cervical spine, and upper dorsal spine.
3. Inside of arm, outside of thigh, lower dorsal spine, and the soles of the feet.
4. Front of the neck, inside of forearm, palm of hand, inside of leg and top of foot.
5. Outside of forearm, outside of leg, and forehead.

The soles of the feet are more sensitive than the palms of the hands. The palms of the hands and the back of the hand are about equally sensitive.

Each of the fifteen different areas tested occupied a certain position of its own in the scale of sensibility to heat and to cold, and the parts that were most sensitive to heat were likewise most sensitive to cold.

In every case a temperature of one degree above the surface temperature appeared warm, while one degree below felt cold, but, at least, when test tubes are used, a slight excess of heat is less readily detected than an equally slight diminution (cold).

Water in a test tube and water into which the hand was dipped gave a sensation of cold at about the same temperature; but water at 34° C. felt warm when the hand was immersed, while in a test tube it was necessary to have a temperature of 39° C. to 41° C.

"Contrary to the opinions of Blix and Goldschneider, but in harmony with those of Dessoir, there are not two separate sets of end organs, one for heat and one for cold."

An article by Dr. V. P. Gibney describes a

Non-Operation Treatment of Metatarsalgia.

This trouble seems to be a neuralgia about the head of the metatarsal bone of the fourth toe, and the author reports cases in which he

has been able to afford relief without excising the bone.

Patients suffering with this trouble instinctively remove the shoe and press the foot between the hands to obtain relief. Believing that a shoe which would imitate this procedure the author had made for some of his patients a Spanish last (a last made with a high instep) and found that shoes made on this, and fitted with a high heel extending toward the centre of the foot gave great relief to most cases.

Dr. Charles L. Dana reports a case of "Gliomatosis of the Spinal Cord and Syringomyelia with Recurrent Hemorrhages." Dr. W. A. Tomlinson writes of the "Genesis of Hallucination, Illusion and Delusion." Drs. F. X. Dercum and W. W. Keen report two cases of "Ingravescent Cerebral Hemorrhage Treated by Ligation of the Common Carotid." Dr. Livingston S. Hinckley writes of the "Difficulties which Prevent the Realization of Dr. Mitchell's Ideal Insane Hospital."

Methylene Blue in Pulmonary Tuberculosis.

Owing to the recommendation of Dr. Althern, of Wiesbaden, Dr. Bronowski, of Professor Tumas's clinic in Warsaw, has employed methylene blue in eight consecutive cases, five of which were in an advanced stage. The remedy was usually given in the dose of 2 to 3 grains (in wafers) three times a day. It was tolerated well by all the patients except one, in whom it occasionally caused sickness. He found that the drug reduced the temperature, but that this effect was much less decided when there was much destruction of lung-tissue. In most cases it diminished night-sweats. In advanced cases it has no effect upon cough, expectoration, or diarrhoea. In incipient cases it may prove of benefit.—*Kansas Medical Journal.*

Benefit to Ear Patients from Nasal Treatment.

Dr. H. Gradle (*Jour. Amer. Med. Association*) says: Acute suppurative inflammation of the middle ear, if not treated has a tendency to become chronic, the tendency increasing with the age of the patient. Chronic suppuration of the middle ear rarely heals without ear treatment. Neither acute nor chronic purulent otitis is influenced by nasal treatment, but the liability to relapses after their cure is decidedly lessened by the removal of naso-pharyngeal anomalies. Acute catarrh of the middle ear will generally terminate in complete recovery under aural treatment, and sometimes even without it, provided there are no persistent nasal or pharyngeal lesions. But when these are present the disease is more likely to become chronic in spite of aural treatment, and in many cases can either not be cured, or if improved, will speedily relapse unless the normal state of the nose and throat is restored. Proliferating or adhesive disease of the middle ear is the consequence of retro-nasal catarrh, and its course is determined by the course of the disorder causing it.—*Toledo Medical Compend.*

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A. M., M. D.

MEDICINE

Rheumatism in Children.

M. Jules Simon calls attention to the multiplicity and anomalies of rheumatic manifestation in children. Infantile rheumatism may attack the vertebral articulations, especially in the suboccipital region. Suboccipital arthritis is, somewhat peculiar to childhood. It must be distinguished from simple torticollis and should not be confounded with cervical Pott's disease.

The tendinous sheaths are often involved. They communicate a sense of crepitation to the finger. They feel as if they were filled with starch. The pangs of rheumatic synovitis are often mistaken for growing pains. The latter, however, are very different from those due to rheumatism. They only occur when the growth has been extremely rapid, as within a few days or weeks. Rest in bed causes them to rapidly disappear. Again their situation is very different from that of rheumatic synovitis. For instance, it is behind the knee that children complain of growing pains, while synovitis is located at the sides and in front of that joint.

The tendency to muscular atrophy is very great in children, but this atrophy readily disappears. M. Simon also indicates the frequency of rheumatic angina in children as well as certain gastric disturbances with repeated attacks of indigestion. Diarrhoea, likewise, is sometimes produced by the rheumatic diathesis. Abundant sweating is another manifestation which often depends upon rheumatism. The child's skin is always wet. He perspires profusely even when at rest or during the night. The sweats coincide with a scanty secretion of urine which is charged with urates. M. Simon does not approve of the custom of allowing children to be bare-legged. He is of the opinion that this fashion is a frequent cause of rheumatic manifestations, particularly erythema nodosum of the legs. As an abnormal localization of rheumatism the writer alludes to the occurrence of more or less painful cystitis. He quotes the case of a young girl of rheumatic taint who was attacked every time that she was chilled by a slight soreness of the throat, followed by a cystitis, which caused extreme pain and sometimes retention of urine to such a degree that it was necessary to use the catheter.—*La Medec. Mod. Med. Bulletin.*

A Premonitory Symptom of Phthisis Pulmonalis.

Destree remarks that in the course of pulmonary phthisis one often observes, without any very obvious cause, inequality of the pupils. This phenomenon is not seen in cases of apical pneumonia, or of bronchitis

with emphysema, but it occurs in chronic pleurisies of old standing. It has a certain diagnostic value.

Destree made experiments on dogs and rabbits, and found that inequality of the pupils could be produced by irritation of the sympathetic in the thorax. When the nerve was stimulated in the neighborhood of the root of the lung, the pupil of the corresponding side dilated. Autopsies on tubercular subjects frequently show that the root of the lung and fibres of the pulmonary plexus are compressed and irritated by enlarged bronchial glands. Tuberculosis of the bronchial glands may therefore manifest itself by dilatation of one pupil several years before other symptoms set in.—*La France Medicale.*

Headache.

WHEN FROM NASAL
STENOSIS.

Generally unilateral.
Frequent insomnia, often worse in the morning.
Aggravated by physical exertion, as running, stooping, etc.
Not subject to conjunctivitis.
Generally nasal catarrh.
Excited by acute coryza.
Nose not suspected by patient.
Dyspepsia and nausea.

Astigmatic chart test negative.
Pressing middle turbinate with probe increases.

WHEN FROM EYE
STRAIN.

Generally bilateral.
Sleeps soundly; improved after sleep.
Aggravated by mental application and using the eyes.
Conjunctivitis after prolonged use of eyes.
Catarrh not complained of.
Not subject to acute coryza.
Eyes believed to be the cause.
Appetite and digestion good.
Same test generally affirmative.
Same test negative, except to cause sneezing.
Sensitive to bright light.

—*Med. Brief.*

Relation of the Pneumococcus to the Symptomatology of Pneumonia.

Numerous observers have found this microbe in various parts of the air passages in persons who were, at the time, in perfect health (*Modern Medicine*). Pasteur has discovered it in the pharynx and neighboring cavities—the nasal fossae, the frontal sinus, the Eustachian tube and even in the bronchi. Netter has shown it to be persistent for an indefinite time in the saliva of persons who had suffered from pneumonia and had recovered. He also frequently observed it in persons who had never suffered from the disease, finding it present in 20 per cent. of 130 healthy persons who had never suffered from pneumonia. Golding Bird found the germ present in 505 of a large number of healthy persons whom he examined, none of whom had suffered from the disease in question.

Cultures of the pneumococcus lose their virulence about the seventh day. It is also

at this date that a rapid desferescence occurs in pneumonia. The so called "crisis" of the disease corresponds with the loss of pathogenic properties of the germ.

It is also noted that the saliva of the patient, which during the development of the disease is extremely virulent, producing pneumonic infection in animals when introduced by inoculation, loses its virulence about the seventh day.

The pneumococcus rapidly loses its virulence under the influence of a temperature of 40° C. (104° F.), and loses all activity when submitted to a temperature of 42° C. This fact coincides with the loss of pathogenic properties which the microbe undergoes under the influence of the high temperature which attends the developing of stage pneumonia.

The pneumococcus does not die, however, at the critical period of the disease, but only temporarily loses its virulence, reacquiring its activity at the end of fifteen or twenty days. This reacquired violence may be retained indefinitely while the microbes reside in the mouth of the recovered patient.

Diet for Typhoid Fever.

Perhaps the best of all diets in typhoid fever is kumyss. The lactic acid which it contains will prevent the growth of the typhoid bacillus. The finely divided state of casein prevents the formation of curds. The carbonic acid is soothing to the irritated condition of the mucous membrane; the taste is grateful to the patient; the acidity stimulates the secretion of the gastric juice, and thus aids digestion—in fact it seems to fulfill all the requirements of a food specially suited to the condition of a typhoid patient or a patient suffering from any serious febrile disorder.—*Ed. Mod. Med.*

Elephantiasis Syphilitica of the Lips.

In a case described by Professor Eichhorst (*Virch. Arch.*) a man, set. forty-three, was attacked five years after the primary affection by a peculiar, diffuse, soft swelling of the lips, producing considerable deformity. Every form of local treatment proved futile. The lower lip, however, was successfully treated with galvano cautery, but two months later swelling of the testes set in. This subsided under pot. iod. treatment. The swelling in the lips then recurred, but was gradually reduced by inunction, only to reappear again after a little time. The patient was finally discharged uncured.

Introduction of Syphilis into Europe.

According to Professor Binz (*Deutsche med. Woch.*) syphilis was undoubtedly first introduced into Europe from America, and it is to the sailors of Christopher Columbus' first expedition that we owe the "malady of France," as Shakespeare has it. Nothing pointing definitely to true syphilis can be found amongst the records of either Jews, Egyptians or Greeks, nor even the writings

of the satirists of Imperial Rome. The latter, it is true, contain descriptions of gonorrhea and the local sore, but no mention is made of the sexual infection spreading over the whole body, becoming constitutional in fact. All authorities, however, agree that in 1495 lues venerea became epidemic in Europe, and subsequently spread over the whole world. Dias de Isla, a physician of Barcelona, states that the malady was imported by the companions of Columbus. During 1494 it was carried into Italy by the armies of Charles VIII, and from Italy it was spread over Europe. Oviedo and Las Casas, contemporaries of de Isla, bear confirmatory evidence.

A critical examination of the works of the authors mentioned will demonstrate their unreliability. Buret's analysis is certainly convincing, and English readers will soon have the opportunity of reading the translation.

Tuberculosis in Childhood.

Goldschmidt reports cases in which the infection was probably of intra-uterine origin.

1. In the lungs of a child aged sixteen months, there were numerous broncho-pneumonic foci and many miliary tubercles. The bronchial, mediastinal and mesenteric glands were enlarged, and the last named caseous. The other organs were intact. On the under surface of the liver, and shining through the peritoneum covering the longitudinal fissure at the entrance of the lig. teres there was a mass of the size of a pea, proved both microscopically and bacteriologically to be tuberculous. 2. In the lungs of a child, aged seven months, there were numerous tuberculous nodules, some of which were partly caseous, as well as cavities varying from the size of a pea to that of a hazel nut. In one as large as a walnut, with the thin purulent contents, tubercle bacilli were demonstrated. There were also numerous intestinal ulcers. At the entrance of the lig. teres there was also a tuberculous mass, and no other tuberculous foci were found in the liver. 3. The infant of a woman subsequently dead of advanced tuberculosis was removed from its mother immediately after birth. It died, when nine weeks old, of atrophy. Numerous large tuberculous nodules, here and there caseating, were found in both lungs, and miliary tubercles in bronchial glands, in the liver, spleen and kidneys. The mesenteric glands were caseous. The tuberculous lesions were here unquestionably of longer duration than the infant's extra-uterine life.—*British Medical Journal.*

Methyl-Blue for Epitheliomata of the Face.

M. Darier reports favorably of this treatment, which he has employed successfully in a series of nine cases. In superficial cases he touches the diseased surface once daily with a 1-to-20 solution. Preliminary cauterization hastens the cure. The drug seems to have a specific action upon the cancerous tissue. If the tumor is deeply seated he uses hypodermatic injections, and if there is extended ulceration skin-grafting is recommended.—*La Tribune Medicale.*

Trional in Delirium Tremens.

Dr. Russell Bellamy, in treating ten cases of delirium tremens with trional, a new hypnotic, records the results of his work in the *New York Medical Journal*, as follows:

1. Delirium was controlled with greater rapidity and safety by trional than by other hypnotics.

2. In the majority of cases a marked stimulant effect was observed, possibly on account of the methylic and ethylic elements which enter into the composition of the drug.

3. On account of the low temperature noted in all cases, trional must possess antipyretic properties, thereby simulating its allies of the phenol group.

4. It was always well borne by the stomach, and in one case was rapidly absorbed when administered per rectum.

5. No unpleasant after-effects were observed, and in all cases, except one, and a tuberculosis complication, recovery was very speedy.—*Maryland Medical Journal*.

Self-Infection in Child Bed.

F. Ahlfeld, in a paper published in the *Zeitschrift f. Geb. und Gyn.*, reaches the following conclusions:

1. The occurrence of fever in child bed, originating without previous examination, cannot longer be doubted.

2. These fevers are, for the most part, unimportant, though severe and even fatal cases are probable.

3. In well-conducted institutions the number of fever cases resulting from self-infection in child-bed is larger than those caused by infection from without. The latter, however, are usually of a severer type.

4. The percentage of morbidity and mortality in an institution in which due care is taken to prevent infection from without, depends on separating the primiparæ from the multiparæ and on the number of operative cases.

5. Preliminary disinfection of the birth canal is an important prophylactic measure.

6. Sublimate remains the best disinfectant.

7. The seat of infection is generally not the external genitals, but rather the cervix and endometrium.

8. Most fever cases in child-bed are to be considered as resorption fever. They result principally from retention of the infectious child bed secretions.

9. The seat of most active absorption is the uterine mucosa; next that of the vagina.

10. The poison taken up is, as a rule, promptly eliminated—probably through the urine.

11. Pathogenic microorganisms are always to be found in the vagina. They need only a favorable culture medium to develop their activity. This they find in the decomposing contents of the vagina and uterus after labor. *Brooklyn Medical Journal*.

The Influence of Oophorectomy on the Voice.

According to an account given in the *Progres medical* for May 5, Dr. Moure, of Bordeaux,

stated at a recent meeting of the *Societe française d'otologie* that in two women who had undergone this operation he had observed that the voice had become strong and coarse. One of them, who had originally had a soprano voice, had lost her high notes and almost become a contralto. The laryngoscopic examination had not shown any anomaly of the vocal organs. Dr. Moure asked if such disturbances of the voice might not be attributed to elongation of the vocal bands or to a more considerable development of the thyroid cartilage.—*N. Y. Medical Journal*.

Tight Lacing and Gallstones.

Prof Marchand, of Marburg, a few years ago called attention in the *Deutsche Medicinische Wochenschrift* to the fact that gallstones and tight-lacing are frequent coincidents. According to Dr. Marchand, the relation of tight-lacing to the development of gallstones is rendered very clear by noticing the situation of the gall ducts in the liver deformed by tight-lacing. The furrow caused by lacing runs directly across the right lobe of the liver, as the result of which there is a tendency to atrophy of the gall bladder. When tight-lacing has been practiced to an extreme degree, an artificial fissure is formed in the liver, giving rise to what is term the "lacing-lobe," which carries with it the gall bladder. The constricted portion of the liver is found to be just at the point of junction of the gall bladder with its duct. In these cases, according to Professor Marchand, it is common to find the gall bladder greatly distended, extending far beyond the border of the liver, and frequently an examination made post-mortem reveals the presence of gallstones.

Stagnation of the bile is well known to be one of the most important causes of the formation of gallstones. A change in the composition of the bile, from catarrh resulting from congestion of the mucous membrane and the thickening of the bile due to failure of the gall bladder to completely evacuate itself, gives rise to the formation of small masses which serve as nuclei for calculi; hence anything which obstructs the free outflow of bile through the cystic duct, must favor formation of gallstones.

Marchand is also of the opinion that many cases of cancer of the liver should be attributed to tight-lacing. It is only a few years since Langenbuch was obliged to open an abdomen to remove a "lacing lobe" of the liver which had been so completely separated from the rest of the organ as to cause its death, rendering its removal necessary.

In view of such facts as these, is it not the duty of every physician to take special pains to warn his patients against the evil effect of this pernicious practice? Few women are conscious of the fact that they are injuring themselves by tight-lacing, and yet at least ninety-nine out of every one hundred women in the United States are addicted to this evil practice in some degree.—*Ed. Modern Medicine*.

SURGERY.

Landmarks of the Digestive Tract.

Dr. F. B. Robinson (*Mathew's Medical Quarterly*) says:

1. The sigmoid flexure is a very apt location for disease to arise. In dissecting infant cadavers I find the sigmoid very long and often lying in the right iliac fossa. In one infant, about six months old, I found a volvulus of the enormous sigmoid. The sigmoid and rectum are inseparable. In the sigmoid 60 per cent of volvulus occur, and men have volvulus four times as often as women. I was unable to produce a permanent volvulus in experimental works on dogs' bowels. When I stitched it the volvulus would unwind, tear out the stitches or lengthen the pedicle. The cause of volvulus is (a) fatness, (b) elongated mesentery, and (c) a history of constipation.

The peculiar disease to which the sigmoid is liable is stricture (malignant or nonmalignant.) Seventy per cent of strictures of the large bowel occur in the descending colon; and this would give a large number to the sigmoid, as the sigmoid is some fifteen inches long, and the descending colon proper is only eight inches long. No doubt the frequent stricture of the sigmoid is due to (a) the sharp and hard foreign bodies which lie on the surface of hard feces, and (b) the mechanical difficulty of passing through the long, curved gut. A curious feature about man is the sigmoid curve and the rectal ampulla, which must represent some ancient evolutionary stage. A peculiar feature I have long noted in autopsies is that the sigmoid and descending colon are frequently more contracted than the other portions of the large bowel.

2 The splenic flexure of the colon is peculiar from being the most fixed and most acute flexure of the digestive tract. It is held firmly in position by the costo-colic ligament. The sharpness of the bend in the colon at the spleen offers considerable mechanical difficulties to the passage of hard feces, and this accounts for both malignant and nonmalignant strictures at this point.

Rough, hard feces wound mucous membrane and allow infection to travel through the gut-wall into the peritoneum, and this wound kept constantly irritated results in inflammation or malignant growths. The inflammatory products organize into connective tissue, ending in contraction or stricture. Tumors and strictures are difficult to diagnose in the splenic flexure, as they are very high under the ribs, and in laparotomy for intestinal obstruction are often overlooked.

3. The hepatic flexure does not give rise to much intestinal disease. It is not an acute flexure, but possesses a very large angle. Its main difficulty is that it is near the gall-bladder, which frequently gives rise to inflammation, and it spreads to the hepatic flexure. It is held to the liver by the hepatocolic ligament. Besides being an obtuse flexure, the feces are not so solid as they are in the splenic and sigmoid flexures.—*American Lancet*.

Iodoform Oil in Tuberculous Joints.

De Vos (*Centblatt. f. Chirurg.; Am. Med. Bull.*) recommends, after repeated experiments on the cadaver, the following as the points of election for injecting the various joints:

1. SHOULDER.—The arm is adducted, the forearm being bent at the right angle across the abdomen, and the needle is introduced one centimeter behind and below the tip of the acromion process.

2. ELBOW.—A point on the outer side of the olecranon, the needle going in between this process, the radial head and the capitulum humeri.

3. WRIST.—On the radial side of the dorsal edge of the styloid process; on the ulnar side at upper edge of the pisiform bone.

4. HIP.—A line is drawn from a point the breadth of the patient's thumb external to half way the distance from the anterior superior spine of the ilium to the pubic spine. From this point another is drawn to the outer edge of the trochanter major. At the junction of the outer and second fourths of this line the needle is introduced, provided the limb is extended, the foot vertical and the trochanter in its normal relation to Nelaton's test line.

5. KNEE.—On the angle between the upper edge of the tibia and the ligamentum patellae.

6. ANKLE.—Immediately in front of the tip of the external malleolus, the needle being pushed between the astragalus and the malleolus.

Injections are to be made very slowly, not more than 10 cm. in five minutes. As to the dose, one gramme of iodoform (10 per cent. to 20 per cent. emulsion) is sufficient for adults to begin with. This is repeated in a week if no reaction follows, and then every fourteen to twenty one days, the iodine in the urine and persisting tender points being the guide.

In the after-treatment massage and passive motion are to be avoided, but moderate active movements are allowable. Several cases of intoxication were observed. Iodoform oil is considered far preferable to combinations of the drug with ether or glycerine. The duration of treatment varied from 9 to 325 days, the injections from one to twenty, and, as a result, 72 per cent. were cured, the ultimate results being better than those following erosion or resection.

Intestinal Indigestion with Fermentation.

R Salol.....	5j
Pancreatin.....	gr. xl
Oleoresin capsici.....	mx

M. ft. in pil. no. 20.

—*Therapeutic Gazette*.

Ingrowing of Nail.

Ingrowing nail, or *ongle incarné*, as the French call it, is, as is well known, a very painful affection, and unfortunately the operation necessary for its cure is often dreaded by the patients, although local and general anesthetics are employed to render the avulsion as painless as possible. A very simple method has been frequently employed by a

confre with constant success. It consists in painting the offending portion of the nail with a warmed 40 per cent. solution of caustic potash. In a few seconds the upper horny layer is rendered so soft that it can be easily removed by a piece of broken glass used as a scraper. The application of the solution and scraping are continued until nothing but an exceedingly thin portion of the nail remains, which can be easily removed by a small scissors. The patient can now be considered as cured, without having lost a drop of blood nor felt any pain.—*Paris Cor. Medical Press and Circular*.

Nerve Suturing.

Dr. De Forest Willard (*International Medical Magazine*) says:

Functional restoration is possible.

The closer the apposition the more speedy and complete will be the restoration.

Union is accomplished chiefly by the reaching out and development of nerve fibres from the divided proximal end, these fibres pushing their way across the connecting link of fibrous tissue. The fan-like projection of these fibres is marked in each case.

Engrafted nerve-tissue or flaps cut from the nerve may serve as a framework for new tissue, or may produce embryonic nerve-fibres capable of assisting in reunion.

ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM SEPTEMBER 9, 1894, TO SEPTEMBER 23, 1894.

Leave of absence for twenty days, to take effect upon the arrival at Fort Schuyler of a medical officer to relieve him, is granted to Captain W. W. Gray, Assistant Surgeon.

Major Peter J. A. Cleary, Surgeon, is relieved from duty at Fort McPherson, Ga., to take effect upon the expiration of his present leave of absence and ordered to Fort Brown, Texas, for duty, relieving Captain William B. Davis, Assistant Surgeon. Captain Davis, upon being relieved by Major Cleary, will report for duty at Fort Brady, Mich., relieving Captain Paul Clendenin, Assistant Surgeon. Captain Clendenin, upon being relieved by Captain Davis, will report for duty at Fort Warren, Mass.

So much of the ordinary leave granted First Lieutenant William F. Lippitt, Assistant Surgeon, as is embraced in the period from August 10 to September 25, 1894, is changed to leave of absence on Surgeon's certificate of disability.

Major Charles Smart, Surgeon, and Captain Harry O. Perley, Assistant Surgeon, are detailed as delegates to represent the Medical Department of the Army at the twenty-second meeting of the American Public Health Association to be held at Montreal, Canada, September 25th to 28th, 1894.

Leave of absence for one month, to take effect after termination of present field duty at Raton, N. M., is granted Major James P. Kimball, Surgeon U. S. Army.

Captain Charles E. Woodruff, Assistant Surgeon, is relieved from duty at Fort Assiniboine, Montana, and ordered to Fort Sheridan, Ills, for duty, relieving Captain Francis J. Ives, Assistant Surgeon.

Captain Ives, on being relieved by Captain Woodruff is ordered to Plattsburg Barracks, N. Y. for duty, relieving Captain Harry O. Perley, Assistant Surgeon.

Captain Perley, on being relieved by Captain Ives, ordered to Baltimore, Md. for duty as Attending Surgeon, and Examiner of Recruits, relieving Captain Louis W. Crampton, Assistant Surgeon.

Captain Crampton, on being relieved by Captain Perley is ordered to Fort Meade, South Dakota, for duty.

Captain Edward C. Carter, Assistant Surgeon, is relieved from duty at Vancouver Barracks, Washington, and ordered to Fort Buford, South Dakota, for duty, relieving Captain Aaron H. Appel, Assistant Surgeon.

Captain Appel, upon being relieved by Captain Carter will proceed without delay to Fort Ethan Allen, Vermont, and report for duty at that post.

The leave of absence for seven days granted Captain C. N. B. Macauley, Assistant Surgeon, is extended twenty three days.

Leave of absence for twenty-one days, to take effect about September 20, 1894 is granted Captain William P. Kendall, Assistant Surgeon.

The leave of absence for seven days, granted Captain Louis Brechemin, Assistant Surgeon, is extended twenty three days.

Leave of absence for one month is granted Major Henry M. Cronkhite, Surgeon.

NEWS AND MISCELLANY.

Twenty-Fifth Annual Session of the Medical Society of Virginia to be Held in Richmond, Va., Beginning October 23d, 1894.

First meeting at 8 P. M., Tuesday, October 23d, 1894, in Hall of Y. M. C. Association, Main and Sixth streets. Fellows, delegates and members by invitation must register their attendance at the registration desk in the hall of meeting.

All subsequent meetings of the Session will be held in the Hall of the Chamber of Commerce, Main and Ninth streets.

The Medical Examining Board of Virginia as at present constituted, will hold its last session for examination of candidates for license to practice in Virginia in the Hall of the House of Delegates, beginning promptly at 9 A. M. Tuesday, October 23d, 1894. The board itself will meet in the same Hall at 8 P. M. Monday, October 22d, for business. All letters with reference to this board, and the examinations should be addressed to the secretary of the board, Dr. Benjamin Harrison, Franklin and Seventh streets, Richmond, Va.

LONDON B. EDWARDS, M. D.

Recording Secretary, etc. (for executive committee).

Richmond, Va., 22d, 1894.